Supreme Court, U.S.
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No.

In The
Supreme Court of the United States

EVELYN S. HARRIS,

Petitioner,

v.

THE STANDARD INSURANCE COMPANY and McNEES, WALLACE & NURICK WELFARE BENEFIT PLAN,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case presents the opportunity for the Court to define and apply ERISA's mandate to provide "full and fair review" for handling ERISA disability claims under the Department of Labor regulations amended in 2000 (applicable to disability benefit claims filed on or after January 1, 2002); to resolve conflicts among the circuit courts as to aspects of "full and fair review"; to apply the "higher-than-marketplace" duty imposed on dual-role, conflicted plan administrators under *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008); and to guide courts in judicial review of plan administrators' conduct in claims determinations, particularly when the violations of ERISA minimum requirements affect the record on review to the prejudice of the claimant.

In order to frame the legal questions distilled from the circumstances in this case, it is necessary to briefly summarize those circumstances. In this case the District Court and Magistrate found no violations of ERISA minimum requirements. The Ninth Circuit Court of Appeals disagreed with only one finding below, and concluded the ERISA fiduciary committed procedural errors by introducing a new reason after the initial denial so that Harris could not respond; nevertheless affirmed the denial, despite numerous other violations;[1] failed to properly consider Harris's additional evidence, which related back to the relevant disability elimination period; affirmed primarily on a single

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[1] 29 C.F.R. §§ 2560.503-1(g)(1)(iii), (h)(2)(ii)-(iii), (h)(3)(i)-(ii), (h)(4), (i)(5), (j)(3), and (m)(4), (8).

medical record during that period, taken out of context, and ignored overwhelming contradictory evidence; failed to mention *Glenn* and to provide any meaningful weighing of factors required by *Glenn*; and applied, without reasoning, a deferential abuse of discretion standard of review.

Against this background, Harris's petition presents the following questions:

1. Do the ERISA statutes and Department of Labor amended regulatory requirements to provide a benefit claimant a full and fair review impose upon plan administrators and insurers a duty to disclose information developed during the pre-suit claim process?

2. Do the substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impaired the development of the claims record, justify affording a substantive remedy to the benefit claimant on the merits or procedural remedies to correct the effects of the violations?

LIST OF PARTIES

The parties to this action are all listed in the caption: The Petitioner, Evelyn Harris, was plaintiff and appellant in the courts below. Respondents Standard Insurance Company and McNees Wallace & Nurick Welfare Benefit Plan were defendants and appellees.

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STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(c)(1) and (f) , and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act (ERISA), a federal law. The Ninth Circuit had jurisdiction under 28 U.S.C. § 1291.

The Ninth Circuit issued its opinion on March 25, 2009. Harris did not seek rehearing.

STATUTES AND REGULATIONS INVOLVED

Title 29, United States Code, Section 1104(a)(1) provides: "[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries" . . . . (D) in accordance with the documents and instruments governing the plan".

Title 29, United States Code, Section 1133(1) provides: "[E]very employee benefit plan shall—(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant."

Title 29, United States Code, Section 1133(2) provides: "[E]very employee benefit plan shall—afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim".

Title 29, Code of Federal Regulations, Section 2560-503-1(g)(1)(iii) (notice of additional information needed to perfect claim), App. 41a.

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Title 29, Code of Federal Regulations, Section 2560-503-1(m)(8) (defining "relevant"), App. 44a.

STATEMENT OF THE CASE

1. The Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*, was enacted to "protect . . . the interests of participants in employee benefit plans and their beneficiaries . . . by establishing standards of conduct, responsibility, and obligation for fiduciaries of [those] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b). ERISA requires plan fiduciaries to act "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . ."; 29 U.S.C. § 1104(a)(1)(A)(i). As part of ERISA's comprehensive enforcement scheme, Section 1132(a)(1)(B) authorizes a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B).

2. This Court has noted that, while Congress derived fiduciary standards from trust law, *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 2348, 171 L. Ed. 2d 299 (2008); *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110-15 (1989), Congress also enacted ERISA because trust law did not offer completely satisfactory protection. *Varity Corp. v. Howe,* 516 U.S. 489, 497 (1996). Thus, in view of ERISA's purposes, the Court enforces ERISA by holding plan fiduciaries to a special duty of loyalty to plan participants and beneficiaries in making benefit determinations. *Glenn,* at 2347-48. The fiduciary duty governs claims administration as well as administration of plan assets. *See* 29 U.S.C. § 1002(21)(A) (granting or denying benefits entails

exercise of discretionary authority). Notably, in creating ERISA, Congress's Conference Committee Report said: "The conferees expect that the courts will interpret this prudent man rule (and the other fiduciary standards) bearing in mind the special nature and purposes of employee benefits plans." *See* H.R. Rep. No. 93-1280, at 302 (1974) (Conf. Rep.), as reprinted in 1974 U.S.C.C.A.N. 5038, 5083.

3. In *Firestone,* this Court relied on the purposes of ERISA and its basis in trust law to determine the appropriate standard of review in an action to recover benefits under an ERISA plan. *Id.* at 108-115. The Court concluded "that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case abuse-of-discretion review applies. *Id.* at 115. The Court noted, however, that more searching review is necessary in the case of a conflicted decisionmaker: "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting *Restatement (Second) of Trusts* § 187, comment d at 403 (1959)).

4. Again based on Congress's intent and purposes in enacting ERISA, the Court in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) declared that plan administrators are held to a standard of duty to participants and beneficiaries that is higher than the duty of a non-ERISA insurer to its insured:

ERISA imposes higher-than-

> marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials," *Firestone*, 489 U.S., at 113 . . . (quoting § 1133(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, *see* § 1132(a)(1)(B).

Id., 128 S. Ct. at 2350.

5. This Court and lower courts agree that a uniform body of ERISA law is necessary to provide guidance on review of ERISA benefit decisions. *See, e.g., Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987) (ERISA fiduciary's responsibilities are established by a uniform administrative scheme, providing standard procedures to guide claims processing and benefit disbursement). In fact, the ERISA regulations create minimum procedural standards for claims processing and benefits payments. 29 C.F.R. 2560-503.1(a) specifically provides: "this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries". As the Department of Labor stated in its Final Regulation, *Employee Retirement Income*

Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure, 65 Fed. Reg. 70246 (November 21, 2000):

> This document contains a final regulation revising the minimum requirements for benefit claims procedures of employee benefit plans covered by Title I of the Employee Retirement Income Security Act of 1974 . . . . The regulation establishes new standards for the processing of claims under . . . plans providing disability benefits . . . . The new standards are intended to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims.[2]

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[2] The Department of Labor stated: "The Department's intentions in including [paragraph (l)] in the proposal were to clarify that **the procedural minimums of the regulation are essential to procedural fairness and that a decision made in the absence of the mandated procedural protections should not be entitled to any judicial deference**. . . . Inasmuch as the regulation makes **substantial revisions in the severity of the standards imposed on plans, we believe that plans should be held to the articulated standards as representing the minimum procedural regularity that warrants imposing an exhaustion requirement on claimants.** In the view of the Department, the standards in the regulation represent essential aspects of the process to which a claimant should be entitled under section 503 of the Act. **A plan's failure to provide procedures consistent with these standards would effectively deny a claimant access to the**

6. Plan administrators must follow the rules' explicit procedures for matters including giving notice, reporting, and claims processing. *E.g.*, 29 U.S.C. § 1021(a) (disclosure to all plan participants); *id.* § 1021(b) (reporting requirements); *id.* § 1133 (claims procedures); 29 C.F.R. § 2560.503-1 (same).

7. But this Court has not spoken on the meaning and implementation of the ERISA regulations, which create the standard minimum procedures for full and fair review, to guide claims processing and benefits disbursement. Nor has the Court indicated what remedies are available for violations of these minimum requirements, especially when the violations prejudice the claimant and impair the record on review. The questions framed here involve whether courts must provide greater, more substantive, if not less deferential review of conflicted plan administrators' adverse benefits determinations when they violate the minimum requirements of ERISA procedures to the claimant's prejudice, and what remedies are due to claimants who are the victims of an improper adverse benefits decision.

8. Petitioner Evelyn Harris was an estate law

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administrative review process mandated by the Act. Claimants should not be required to continue to pursue claims through an administrative process that does not comply with the law. At a minimum, claimants denied access to the statutory administrative review process should be entitled to take that claim to a court under section 502(a) of the Act for a full and fair hearing on the merits of the claim." *Id.* at 70255-56 (emphasis added). "By establishing a more complete, **uniform set of minimum requirements** the regulation will reduce the complexity of claims processing requirements, thereby increasing efficiency." *Id.* at 70260 (all emphasis added).

attorney and partner at the Pennsylvania law firm, McNees Wallace & Nurick (March 1, 2001-July 31, 2002) and a participant in the Respondent McNees Wallace & Nurick Plan, of which Standard Insurance Company is the plan administrator. Harris consulted Dr. Megan Borror in October 2001, regarding symptoms of pain, chronic fatigue, and cognitive issues. Harris consulted Dr. Jacob Teitelbaum on December 23, 2002, for the same issues. She stopped working on June 28, 2002.

9. On January 25, 2003, Harris filed a claim for long term disability benefits. App. 85a. Dr. Teitelbaum prepared an Attending Physician Statement (APS) identifying diagnoses causing disability, including chronic fatigue syndrome, pain, and cognitive dysfunction. App. 86a. Harris stated June 28, 2002, as her date of disability because of "fatigue, cronic [sic] pain, reduced ability to concentrate". *Id.*

10. In reviewing Harris's submission, Standard Disability Claims Specialist Steven Poindexter obtained a record review from physician-consultant Dr. Sheila Ingram. Dr. Ingram "recommend[ed] obtaining any psychiatric or neurocognitive testing records if present", thus noting that the file lacked any neuropsychological evaluations, which would address the cognitive issues. App. 87a.

11. Standard denied the claim in a letter by Poindexter dated April 25, 2003. App. 45a-49a.

12. Contrary to 29 C.F.R. § 2560-503-1(g)(1)(iii), the April 25, 2003 letter did not mention the reviewer's specific request for a neuropsychological evaluation as "additional information" necessary to perfect the claim. *See*

App. 87a ("I recommend obtaining any psychiatric or neurocognitive testing records if present").

13. Contrary to 29 C.F.R. § 2560-503-1(j)(3), the denial letter did not notify Harris "in a manner calculated to be understood by the claimant" that she was entitled to receive, on request and free of charge, access to and copies of all documents, records, and other information relevant to her claim.

14. Though Harris did not have a copy of the claim file, including Dr. Ingram's recommendation to obtain any neuropsychological evaluations, Harris's husband, Norman Hessel, a Northwestern Mutual agent with experience selling disability coverages, submitted her appeal.

15. Contrary to 29 C.F.R. § 2560.503-1(h)(3)(ii), Standard presented the appeal to the same claims analyst (Poindexter) and physician-consultant (Ingram) who examined the original claim.

16. Poindexter issued a second denial dated September 24, 2003 ("interim denial letter"). App. 50a-55a. It is undisputed that this interim denial letter violated procedural regulations by stating a new reason for denial, App. 3a: that Harris failed to provide documentation of cognitive problems with a neuropsychological evaluation, which Standard opined one would expect in order to satisfactorily demonstrate neurocognitive impairment sufficient to impair work ability. App. 53a. The letter meets the definition of an "adverse benefit decision" under 29 C.F.R. § 2560.503-1(m)(4), as the Ninth Circuit implied. But importantly, the letter did not offer the further right to appeal this new adverse benefit decision. Thus, this second or new adverse decision, contrary to 29 C.F.R. § 2560.503-1(g), (h)-(j), and (m),

failed to meet every minimum procedural requirement regarding full and fair review and notice of the right to appeal.

17. So, without any further appeal, on October 23, 2003, Benefits Review Specialist Mark Sampson of Standard's Quality Assurance Unit (Standard's Appeal Unit) issued the final denial letter, also noting the absence of neuropsychological testing, which Sampson said undermined the legitimacy of Harris's complaints. App. 56a-59a.

18. Contrary to 29 C.F.R. § 2560.503-1(g)(1)(iii), deposition testimony of Standard's Poindexter and Sampson demonstrated a company-wide practice and procedure, despite ERISA regulation training, of disregarding the regulation's requirement to describe additional information necessary to perfect the claim along with an explanation of why that information would be necessary. Poindexter and Sampson testified that this advice was not their responsibility. App. 73a-81a.

19. On judicial review of Standard's conduct in denying the claim, the Magistrate found it "troubling . . . that Standard did not act on Ingram's recommendation to obtain records of any psychiatric or neurocognitive tests, . . . in its April 23 letter." App. 28a. He concluded, however, that Standard provided full and fair review because the interim letter preceded the review required by the regulations and therefore "Standard was not required to issue the Section 503-1(j)(3) notification statement in *advance* of the statutorily prescribed review." App. 26a. The Magistrate granted Standard's motion to strike Harris's additional evidence relating back to the relevant 180-day

elimination period for determining her disability. App. 33a-35a.

20. On Harris's motion to reconsider and revise the Magistrate's decision, the District Court adopted the Magistrate's Findings and Recommendation to dismiss the claim, affirming Standard's denial. App. 5a-6a. The District Court sustained the Magistrate's ruling granting Respondents' motion to strike and excluded the following evidence offered by Harris:

- neuropsychological testing by Dr. Sandman, documenting significant ongoing cognitive problems during the elimination period, App. 82a-83a ;
- Dr. Teitelbaum's declaration responding to Standard's reasons for denial and relating Harris's cognitive and other symptoms back to the time before his treatment (the elimination period), App. 60a-61a;
- Harris's declaration explaining her disability specifically and in detail, and that she did not know her rights regarding her claim until after the administrative record was closed, App. 62a-66a; and
- Hessel's declaration providing his understanding, based on the information Standard had given him but without the information it withheld, of the claim and appeal. App. 67a-72a.

The District Court did not comment on the Magistrate's conclusion that Standard made no significant violations of ERISA.

21. On Harris's appeal to the Ninth Circuit, without oral argument, the Court of Appeals affirmed in a short unpublished Memorandum, App.

1a-4a. The Court concluded that Standard committed procedural violations in the September 24, 2003 interim denial letter by including new explanations for the denial without giving Harris an opportunity to submit additional evidence to address those explanations. App. 3a. But the Court concluded none of the violations "Standard may have committed . . . amount to the 'wholesale and flagrant violations' required for de novo review." App. 2a-3a. The Court observed that the District Court should have weighed the violations as a factor in reviewing for abuse of discretion. The Court stated that it was considering Harris's newly submitted evidence, which it was the first to do. However, contrary to *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), the Court of Appeals credited one statement in Dr. Borror's records (just as the District Court had done) over later-acquired evidence of disability directly on point during the relevant period. App. 3a-4a. In this respect, the Ninth Circuit erred dramatically by misunderstanding Dr. Borror's record, which clearly pertained only to Harris's depression and not to the combination of conditions rendering Harris unable to work. App. 87a. The Court concluded Standard did not abuse its discretion in denying benefits, and affirmed the District Court.

22. The Ninth Circuit's ruling illustrates a conflict among the circuits as to whether a plan administrator is obligated to share information collected during the appeal with the claimant. *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005); *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870, 872-73 (9th Cir. 2008); *Booton v. Lockheed Medical Benefit Plan*, 110

F.3d 1461, 1463 (9th Cir. 1997). *But see Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007); *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008).

23. A conflict also exists regarding the substantive remedies to which a claimant is entitled when the plan administrator has committed substantive violations, impairing the development of the claims record, of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations. Specifically, the circuits divide over whether the reviewing court must allow additional evidence to supplement the impaired record and to what extent. *Saffon*, 522 F.3d at 872-73; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc) (district court may consider evidence outside the administrative record to decide any conflict of interest; noting conflict in circuits).

REASONS FOR ALLOWING THE WRIT

This case presents the Court with the opportunity to resolve and provide guidance on the meaning of the "higher-than-marketplace"[3] obligations imposed under ERISA statutes and regulations in the plan administrator's performance of the duty to conduct full and fair review of an adverse benefits decision, and to provide notice of the right to appeal that decision. It offers the Court an opportunity to provide guidance on what follows when procedural violations of the ERISA statute or Department of Labor impair the development of the

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[3] *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2350, 171 L. Ed. 2d 299 (2008).

record, prejudicing a claimant. These questions arise frequently in litigating ERISA claims and transcend decisions regarding the applicable standard of review recently articulated in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008).

The Ninth Circuit's decision in this case presents two conflicts between the circuits: (1) the obligations of an ERISA plan or insurer to disclose information pre-suit (*Abram v. Cargill, Inc.,* 395 F.3d 882, 886 (8th Cir. 2005); *Saffon v. Wells Fargo & Co. Long Term Disability Plan,* 522 F.3d 863, 870, 872-73 (9th Cir. 2008); *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). *But see Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007); *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008)); and (2) whether and to what extent the reviewing court should admit additional evidence beyond the administrative record (*Saffon,* at 870-73; *Booton,* at 1463; *Abatie v. Alta Health & Life Ins. Co.,* 458 F.3d 955, 970 (9th Cir. 2006) (en banc) (circuits cited therein)). These conflicts call for this Court's review under this Court's Rule 10(a).

Moreover, the Court should grant certiorari because the Ninth Circuit decided important questions of federal law that this Court has not addressed (Rule 10(c))—namely, how the 2000 regulations implementing ERISA satisfy ERISA's mandate for full and fair review—and because the Ninth Circuit's decision so far departs from the accepted and usual course of judicial proceedings, and sanctions such a departure, as to call for this Court to exercise its supervisory power. Rule 10(a). In granting certiorari and exercising its supervisory

power, the Court should amplify and implement its holding and the Department of Labor's intent that our judicial system must follow a uniform procedure and method in reviewing ERISA benefits claim decisions.

What occurred here presents precisely the problem with the absence of such a judicial system. The Magistrate and the District Court erred as a matter of law in ruling that Standard reached its interim decision before the "full and fair review" process required by the ERISA regulations, and that therefore the interim decision did not trigger full and fair review.

This interpretation of the law and the applicability of the Department of Labor regulations defies logic. The Ninth Circuit correctly reversed that aspect of the District Court's Order by recognizing the interim letter could only be an adverse benefit decision, but then abandoned the ERISA statutes' and Department of Labor's minimum requirements flowing from that conclusion: that is, Standard committed clear violations of 29 C.F.R. § 2560.503-1(g)(1)(iii) (which it admitted it does not follow); 29 C.F.R. § 2560.503-1(h)(2)(iii), (h)(4), (h)(3)(i), (j)(3), and (m). The impact of those violations, as explained here, impaired the record so severely as to prejudice Harris and eviscerate ERISA's mandates. The Ninth Circuit, in its stunted and contradictory analysis of ERISA statutes and regulations, also improperly and inadequately weighed, or failed to weigh, the violations along with Harris's additional evidence, or to give Harris an opportunity to supply the needed information to support her claim, so that she could rectify the record impaired by the ERISA violations.

In essence, the decision points to the unsettled nature of the meaning of full and fair review based on "higher-than-marketplace" standards applied to ERISA plan administrators, and the remedies for violations of the full and fair review obligations. Harris asks the Court to accept review of the legal errors made by the lower courts in order to remedy the great injustice done to her and to prevent this injustice from affecting other claimants who, by the gap in directions for judicial review, are left to the discretion of conflicted, biased ERISA plan administrators. The Court should address and resolve the above questions in accordance with ERISA's mandates. For all these reasons, the *Harris* decision merits this Court's review.

I. THE CONFLICTS ILLUMINATED BY *HARRIS* MERIT THIS COURT'S REVIEW.

A. The Circuits Conflict Over The Obligations Of An ERISA Plan Or Insurer To Disclose Information Pre-Suit.

The Ninth Circuit's ruling in this case illustrates a conflict among the circuits as to whether a plan administrator is obligated to share information collected during the appeal with the claimant. In *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005), interpreting the regulations for full and fair review before they were amended, 29 C.F.R. § 2560.503-1(h)(2000), the Eighth Circuit held:

> Full and fair review includes the right to review all documents, records, and other information relevant to the

claimant's claim for benefits, and the right to an appeal that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim. 29 C.F.R. § 2560.503-1(h)(2000). This circuit has held that these procedures allow a claimant to "adequately prepare herself for any further administrative review, as well as an appeal to the federal courts. The statute and the regulations were intended to help claimants process their claims efficiently and fairly." . . . "The persistent core requirements" of full and fair review include "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Grossmuller v. Int'l Union, UAW*, 715 F.2d 853, 858 n.5 (3rd Cir. 1983). ERISA and its accompanying regulations essentially call for a "meaningful dialogue between the plan administrators and their beneficiaries." *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997). Plan procedures cannot be "full and fair" without providing for this communication. *See Marolt v. Alliant Techsystems, Inc.*, 146 F.3d 617, 620 (8th Cir. 1998) (holding that ERISA

> claimants are entitled to "timely and specific" explanation of benefit denials, and may not be "sandbagged" by post-hoc justifications of plan decisions).[4]

Abram relied on the Ninth Circuit's decision in *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997), followed more recently by *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870-73 (9th Cir. 2008). *Saffon* and *Booton* require disclosure of material developed pre-suit, as part of the "meaningful dialogue" guaranteed by ERISA. Interpreting the pre-amendment regulation (29 C.F.R. § 2560.503-1(f)(2000)), *Booton* held:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language,

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[4] *But see Midgett v. Wash. Group Int'l Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir., April 15, 2009) (based on amendments applicable to disability benefit claims filed on or after Jan. 1, 2002, 29 C.F.R. 2560.503-1(h)(3)(iii), (i)(5), (j)(3), (j)(4), (j)(5). m(8), "the full and fair review to which a claimant is entitled under 29 U.S.C. § 1133(2) does not include reviewing and rebutting, prior to a determination on appeal, the opinions of peer reviewers solicited on that same level of appeal"). A conflict continues to exist between the Tenth and Eleventh Circuits, and the Ninth Circuit (disclosure through meaningful dialogue, implementing Department of Labor's intent, *see* n. 2, *supra*). In the amendments, the Department of Labor clearly made the minimum standards more stringent, not less. The reasoning in *Abram* remains sound, though *Midgett* essentially joins the Tenth and Eleventh Circuit in this conflict.

> with specific reference to the plan provisions that form the basis for the denial; **if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it.** There is nothing extraordinary about this; it's how civilized people communicate with each other regarding important matters.
>
> * * *
>
> . . . [T]o deny the claim without explanation and without obtaining relevant information is an abuse of discretion. . . . *cf. Halpin* v. *W.W. Grainger, Inc.*, 962 F.2d 685, 691 (7th Cir. 1992)(an ERISA plan cannot rely on a lack of information to support its denial of benefits when it fails to inform the beneficiary about the missing information so that the beneficiary can provide it).

Id. at 1463 (emphasis added).

In *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 870-73 (9th Cir. 2008), the court elucidated the meaning of "meaningful dialogue" where, as here and in many other instances, the plan administrator adds a new reason for the benefits denial. In that frequently-occurring event, the district court reviewing the denial must give the claimant an opportunity to present evidence on the newly-raised reason, that is, "objective evidence of whether she is totally disabled under the terms of the Plan." *Id.* at 872-73. Next, in determining the degree of deference to which the

plan administrator is entitled on judicial review, the district court must consider the course of dealing with the claimant. *Saffon* holds that a plan administrator violates its duty to have a meaningful dialogue with its beneficiary by means of precisely the same tactics Standard used here: opaque communications and taking Dr. Borror's statement out of context or otherwise distorting in an apparent effort to support denial (citing John H. Langbein, *Trust Law as Regulatory Law,* 101 Nw. U. L. Rev. 1315, 1319 (2007), an authority followed by this Court in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008), noting a physician claims reviewer's allegation "that he was instructed 'to use language to support the denial of disability insurance'; that he was not allowed 'to request further information or suggest additional medical tests'; and that he was 'not supposed to help a claimant perfect a claim'"). Finally, *Saffon* holds that after determining the degree of deference (if any) it should accord the insurer's decision, the district court must take into account such additional evidence as the claimant may present and any contrary evidence the insurer may present. The court warned, however, that the admission of significant new evidence will require *de novo* reconsideration of the decision.

But the Tenth and Eleventh Circuits disagree. In *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161, 1167-68 (10th Cir. 2007), interpreting the amended regulation, the Court reasoned that requiring a plan administrator to grant a claimant the opportunity to review and rebut medical opinions generated on administrative appeal "would set up an unnecessary cycle of submission, review, re-

submission, and re-review", which "would undoubtedly prolong the appeal process" (citing 29 C.F.R. § 2560.503-1(i)(3)(i)). The Eleventh Circuit held in accord with the Tenth in *Glazer v. Reliance Std. Life Ins. Co.*, 524 F.3d 1241, 1245-1246 (11th Cir. 2008).

The *Harris* decision illuminates this conflict. The Court recognized the undisputed procedural violations Standard committed, particularly by "including new explanations for its denial of benefits in the 'interim' denial letter of September 24, 2003, without giving Harris an opportunity to then submit additional evidence relevant to those explanations." App. 3a. The Court even cited *Saffon* and *Abatie*. App. 3a. Nevertheless, the Court overlooked that the record showed numerous egregious violations underlying the only violation it identified:

1. Standard's failure to share its reviewer's specific recommendation and request for any neuropsychological evaluation because a neuropsychological evaluation was necessary to perfect the claim. The Ninth Circuit could not have more clearly identified this as a violation in *Saffon*, at 873, relying on Langbein's note that a physician consultant "was not allowed 'to request further information or suggest additional medical tests'; and that he was 'not supposed to help a claimant perfect a claim'". The Magistrate found this violation only "troubling", and excused it as not amounting "to a procedural violation" because "Standard was not required to provide an exhaustive list of every possible piece of medical evidence that could conceivably strengthen Harris' application"; because he believed Harris had an opportunity to supplement the

administrative record before the final decision; and because there was no suggestion in the record that "psychiatric or neurocognitive testing might have significantly modified the conclusions Standard drew from these facts." App 30a. The Ninth Circuit disagreed, correctly calling Standard's conduct what it was: a violation identical to that outlawed in *Saffon*, 522 F.3d at 871-73, and *Abatie*, 458 F.3d at 970. App. 3a.

2. Standard's failure to notify Harris in the first denial letter of this specific additional information necessary to perfect her claim, in violation of 29 C.F.R. § 2560.503-1(g)(1)(iii).
3. Standard's admission that it routinely disregards the additional information regulation, 29 C.F.R. § 2560.503-1(g)(1)(iii).
4. Standard's submission of the review to the same analyst and medical examiner as in the initial review. 29 C.F.R. § 2560.503-1(h)(3)(ii) and (v).
5. Standard's failure to identify the medical experts "whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination". 29 C.F.R. § 2560.503-1(h)(3)(iv).
6. Standard's failure in the interim and final denial letters to notify Harris that she had a right to request and obtain the claim file which would have revealed the request and need for a neuropsychological evaluation. 29 C.F.R. § 2560.503-1(j)(3).
7. Standard's selective emphasis, if not sole reliance, on Dr. Borror's report that Harris's depression had "markedly improved" (in Standard's words): Magistrate's decision, App.

13a; April 25, 2003 denial, App. 46a, 47a; Sept. 24, 2003 interim letter, App. 54a), knowing that a neuropsychological evaluation might have illuminated the contradiction between that statement and Dr. Teitelbaum's pre-suit information (which Standard rejected). This error conflicts directly with this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2352, 171 L. Ed. 2d 299 (2008). Ironically, the Ninth Circuit believed Dr. Borror's notation of improvement related to Harris's disability based on all her diagnoses and symptoms (*e.g.*, pain, fatigue, cognitive problems), App. 4a, despite the fact that Dr. Borror clearly indicated to the contrary that it pertained only to Harris's depression. App. 87a.

Standard did not do any of the required acts in the first, interim (second) and final adverse benefit decision letters. These procedural violations not only identify a conflict in the circuits but also require a substantive remedy as to which there is another conflict in the circuits: whether and to what extent the reviewing court should allow additional evidence to supplement and correct the record impaired by the above violations.

In the event that the writ is allowed, Harris will argue that the ERISA statute and Department of Labor regulations' requirements to provide a benefit claimant a full and fair review impose upon plan administrators and insurers a duty to disclose information developed during the pre-suit claim process, along with an opportunity to respond. If ERISA plans or their insurers violate these requirements, then it is up to the District Court to take additional evidence to complete the record.

B. The Circuits Conflict Over Whether And To What Extent The Reviewing Court Should Admit Additional Evidence Beyond The Administrative Record.

In *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc), the Ninth Circuit held: "The district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise." The Court noted the conflict in the circuit courts:

> Many circuits limit a district court to the administrative record when the court is reviewing a case on the merits for an abuse of discretion; consideration of new evidence is permitted only in conjunction with *de novo* review of a denial of benefits. *See Urbania v. Cent. States, Se. & Sw. Areas Pension Fund*, 421 F.3d 580, 586 (7th Cir. 2005) . . . [*Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n.5 (3d Cir. 2004)], (noting that, "in general, the record for arbitrary-and-capricious review of ERISA benefits denial is the record made before the plan administrator"), [*cert. denied*, 544 U.S. 1044 . . . (2005)]); [*Fought v. Unum Life Ins. Co. of Am.*,

> 379 F.3d 997, 1003 (10th Cir. 2004)] (noting that courts are limited to the administrative record when reviewing for abuse of discretion); *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 173 (2d Cir. 2001) (noting that when review is for abuse of discretion, the record consists of the administrative record); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 &n.6 (4th Cir. 1999) (noting that on *de novo* review, a court may consider extra-judicial evidence, but stating that abuse of discretion review must be based on the evidence before the administrator); [*Vega v. National Life Ins. Servs.*, 188 F.3d 287, 300 (5th Cir. Tex. 1999)] (restricting review to the administrative record when the court is considering the administrator's factual determinations for abuse of discretion); *Buckley v. Metro. Life*, 115 F.3d 936, 941 & n.2 (11th Cir. 1997) (per curiam) (holding that extra-record evidence, presented to the district court on review for abuse of discretion, was irrelevant).

As of the writing of this Petition, none of these decisions cited in *Abatie* as conflicting on this issue have been since overruled or modified.

This conflict presents the opportunity for the Court to decide that substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impair the development of the claims record, justify allowing additional evidence as necessary to correct the deficient record.

II THIS COURT SHOULD EXERCISE ITS SUPERVISORY POWER TO DECIDE IMPORTANT QUESTIONS OF FEDERAL LAW AS TO WHETHER FULL AND FAIR REVIEW REQUIRES THE REVIEWING COURT TO GIVE MEANINGFUL, ADEQUATE WEIGHT TO UNDISPUTED PROCEDURAL VIOLATIONS

A. There Is A Gap In Important Questions Of Federal Law As To The Mandate For Full And Fair Review.

This Court's recent decision in *Metropolitan Life Ins. Co. v. Glenn,* 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008) requires weighing of a combination of factors, *id.* at 2351, but it does not indicate how to do this in a manner that implements full and fair review through judicial enforcement of the regulations.

Harris conflicts with *Glenn*. *Glenn* holds that review under heightened scrutiny applicable to a conflicted plan administrator requires a balancing of factors to determine the impact of a conflict on the benefits decision *Id.* at 2351-52. No one factor is determinative except as a tiebreaker. *Id.* at 2351.

The Ninth Circuit in this case failed to follow *Glenn* in several respects: Instead of articulating what combination of factors it weighed, the Court relied on only one factor—the procedural violation of basing a denial on a new reason (lack of a neuropsychological evaluation). As described above, the Court stopped short of acknowledging that this one violation incorporates and triggers a host of other violations. Nevertheless, the Ninth Circuit

concluded, without explanation, that whatever violations Standard may have committed did not rise to the "wholesale and flagrant" level required for *de novo* review. Thus, the *Harris* decision demonstrates that this Court has not determined what degree of violations by a conflicted plan administrator would trigger *de novo* review, or how significant the violations must be to reach even the highest level of skeptical abuse-of-discretion scrutiny.

In addition, *Harris* directly ignores the *Glenn* Court's reliance on the critical "serious concern" arising when, as in this case and *Glenn,* the plan administrator and the reviewing court selectively emphasize (or solely rely on) one medical report while de-emphasizing (or completely ignoring) another. *Glenn* affirmed the Sixth Circuit Court of Appeals' consideration of "[a]ll these serious concerns, taken together with some degree of conflicting interests" on the part of the plan administrator, in setting aside MetLife's adverse benefit decision. *Glenn,* 128 S.Ct. at 2352. But here, the Ninth Circuit either weighed no other factors or concerns that conclusively exist, or inadequately weighed them, in either case neglecting to follow this Court's directives. The Ninth Circuit merely paid lip service to the *Glenn* requirements, undercutting the importance of the higher-than-marketplace standards.

B. The *Harris* Decision's Failure To Conduct A Meaningful Weighing Of Factors Calls For An Exercise Of This Court's Supervisory Power.

The Ninth Circuit's improper analysis here

justifies a grant of certiorari to instruct courts that under *Glenn* and prior law, courts and plan administrators must enforce ERISA's "full and fair review" expressed in its statutory and regulatory mandates. The Court should exercise its supervisory power to settle these crucial questions of federal law affecting all ERISA claimants.

As demonstrated above, by giving inadequate weight to the plan administrator's admitted and uncontradicted violations of the ERISA statute and Department of Labor regulations, which impaired the pre-suit record and prejudiced the beneficiary's claim, the Ninth Circuit failed to enforce full and fair review.

All levels here ignored one factor that alone should have been determinative: the plan administrators' direct admission that they violated, and regularly have a practice and procedure of violating, the 29 C.F.R. § 2560.503-1(g)(1)(iii) requirement to inform the claimant what specific additional information she should provide to assist the plan and the claimant in determining whether she is entitled to benefits (that is, perfect the claim), and why. Neither the review committee, the District Court, nor the Ninth Circuit Court of Appeals considered, much less evaluated the meaning of this fatal fact. Yet no weighing or balancing should be necessary when the plan admits knowing violations of the law or in other ways refuses to meet minimum procedural requirements. In fact, this evidence suggests a pattern and practice within Standard to disregard important Department of Labor regulations, practices reminiscent of Langbein's description of UNUM's misconduct, found only after an external claims audit.

The *Glenn* Court split over the guidelines as to "how" the conflict should "be taken into account on judicial review of a discretionary benefit determination." The plurality chose the "combination of factors" approach, commenting that "any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue [in that case], for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, in other words combination-of-factors method of review." *Glenn,* 128 S. Ct. at 2351.

Justice Scalia, dissenting, called for a predictable set of liabilities under uniform standards of primary conduct. He noted that the *Restatement of Trusts* instructs a court to inquire into four categories of abuse of discretion separately, using different measurements. One type of abuse of discretion occurs as follows: a trustee acts unreasonably when their decision is substantively unreasonable either with regard to their exercise of a discretionary power or with regard to their assessment of whether the preconditions to that exercise have been met. *Restatement (Second) of Trusts* § 187, comment i (1959).[5]

Standard's conceded disregard of an external standard, 29 C.F.R. § 2560.503-1(g), among other violations, should be recognized as a blatant abuse of discretion: "the existence or nonexistence, the

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[5] The *Restatement (Third) of Trusts* was issued in 2007; the sections therein pertinent to the above discussion are 50 and 87.

definiteness or indefiniteness, of an external standard by which the reasonableness of the trustee's conduct can be judged". *Restatement,* § 187, comment d. As noted in comment i, "If there is a standard by which the reasonableness of the trustee's judgment can be tested, the court will control the trustee in the exercise of a power where he acts beyond the bounds of a reasonable judgment, unless it is otherwise provided by the terms of the trust." In other words, the violation of an external standard for measuring the decisionmaker's reasonableness, by itself, is a breach of fiduciary duty.

"A reasonable decision is one over which reasonable minds seeking the 'best' or 'right' answer could disagree." *Glenn,* at 2360 (Scalia, J., dissenting). But as noted, where the decisionmaker admits reckless or intentional violation of the external standard of reasonableness, there is no need to weigh factors. The multiple violations of ERISA regulations constitutes abuse of discretion as a matter of law.

In this case, the Ninth Circuit should have recognized that Standard's admission that they directly and regularly violate § 2560.503-1(g)(1)(iii), combined with their numerous violations of the regulations' other minimum required procedures for full and fair review and notice, compounded by the District Court's refusal to consider contemporaneous medical opinions in later-submitted materials, all showed absolute abuse of discretion, or alternatively, as the Court of Appeals put it, "wholesale and flagrant" violations that trigger *de novo* review.

As analyzed by Langbein, the scandalous problems in ERISA insurer Unum's ERISA claims

management can be found in most if not all insurers that are inherently conflicted plan administrators. John H. Langbein, *Trust Law As Regulatory Law: The UNUM/Provident Scandal and Judicial Review of Benefit Denials Under ERISA,* 101 Nw. U. L. Rev. 1315, 1317-21 (2007) (describing UnumProvident's behavior). In this case, though no one has audited Standard to reveal their widespread violations characteristic of Unum, the testimony of Standard claims analysts in this case expressly admits such violations in the form of Standard's company-wide culture, bias, and policy of ignoring the additional information regulation. Moreover, the denial letters on their face prove, and the claims file confirms, the same.

Because ERISA fiduciaries, unlike private trustees who have no stake in the trust corpus, are aligned with the employer or insurer, deference has no place in the context of this conflicted relationship. Thus, in construing ERISA's fiduciary duties, trust principles, which allow discretion and deference, should yield to ERISA's mandates. Granting a writ in this case would allow the Court to substantially clarify and call a halt to conflicted plan administrators' continued violations of ERISA and abuse of the discretion that the law has allowed them thus far, violations that prejudice claimants by impairing the development of the record for reviews.

III. THE COURT SHOULD SETTLE THE QUESTION WHETHER SUBSTANTIVE VIOLATIONS OF ERISA STATUTES (29 U.S.C. § 1133) AND DEPARTMENT OF LABOR REGULATIONS THAT IMPAIR THE

DEVELOPMENT OF THE CLAIMS RECORD JUSTIFY ACCORDING A SUBSTANTIVE REMEDY TO THE BENEFIT CLAIMANT

A. The Ninth Circuit Failed to Meaningfully Consider Harris's Additional Evidence.

The Ninth Circuit was the first court to consider Harris's additional evidence, which she submitted at the District Court level. But the Ninth Circuit erred dramatically by literally and impermissibly finding "Harris submitted no contemporaneous medical evidence of her inability to work for the entirety of the relevant six-month disability waiting period." App. 3a-4a. This decision improperly excluded all evidence other than the one statement in Dr. Borror's records, just as the District Court did, taking that one record out of context just as the District Court did. *See* App. 87a. The Ninth Circuit said it was considering additional evidence but did the opposite. Since the Court did not explain what led it to decide that the additional evidence did not overcome Harris's comment to Dr. Borror on November 5, 2002 that she felt "100% better" (relating only to depression and not ongoing pain, fatigue and cognitive problems), App. 87a, which Standard and the reviewing courts seized upon as fatal to Harris's disability claim, one can only conclude that the Court erred by not meaningfully weighing the additional information under *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc) and as implied by *Glenn*. The additional information, adequately considered, amounts to substantial proof of Standard's egregious

bias against finding disability and granting Harris disability benefits. The Court articulated a remedy of allowing additional evidence outside the administrative record but then did not follow through on the remedy by providing Harris to more fully supplement the record. This Court should allow review of *Harris* in order to breathe life into the remedies courts can grant benefits claimants who are denied full and fair review.

The Magistrate granted Standard's motion to strike all of this additional evidence: a neuropsychological evaluation by Curt Sandman, M.D., reviewing and opining on the relevant disability period; a declaration by Harris's treating physician, Dr. Teitelbaum, who submitted the Attending Physician Statement supporting her original claim; Harris's own declaration and that of her husband explaining how they supported her claim in reliance on Standard's misleading claims handling. The Magistrate struck these materials on the ground that they went "strictly to the merits of Standard's benefits decision rather than to establishing conflict of interest, and therefore cannot be admitted pursuant to the conflict of interest exception" articulated in *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 970 (9th Cir. 2006) (en banc). App. 35a. The District Court adopted that reasoning. App. 6a. The Ninth Circuit reversed the grant to strike evidence, but affirmed anyway. App. 3a.

In sum, the Ninth Circuit failed to provide Harris with full and fair review when it selected out a single record and ignored other supporting evidence of Harris's disability during the relevant elimination period, without explaining why or how it

reached this decision. Granting certiorari in this matter will provide the Court a platform for instructing future courts to enforce full and fair review.

B. Enforcement Of ERISA Statutes And Regulations' Mandate For Full And Fair Review Should Also Be Available Through A Grant Of Retroactive Benefits Or Remand To The District Court For *De Novo,* Non-Deferential Review Along With Record Supplementation.

Certiorari is also warranted to respond to the confusion among the circuits and within them as to what a reviewing court should do to remedy a claimant deprived of full and fair review through an adverse benefits decision. The substantive violations of ERISA statutes (29 U.S.C. § 1133) and Department of Labor regulations, which impaired the development of the claims record, justify affording a substantive remedy to the benefit claimant, requiring reversal with a grant of retroactive benefits to Petitioner Harris, or remand to the District Court for *de novo* or non-deferential review and the right to supplement the record addressed above.

The slew of errors the lower courts have sanctioned here demonstrates the need for review by this Court. For a direct, company-wide practice and procedure of violating regulations as Standard admitted here, the remedy should be to deem the benefits denial reversible error at every level of review, as a matter of law.

Short of that, the Court should allow the

Plaintiff the opportunity to develop and the District Courts to admit and consider additional evidence to determine whether the plan fiduciary's benefits determination was proper, regardless of standard of review; allow *de novo* review; and require an order for broader discovery under the merits of the claim.

For improper notice and lack of review, the remedies should be the same. As exemplified here, neither Harris nor any reviewing court could know what additional evidence would have been developed to address the disability determination because (1) Standard never told the claimant what they knew she needed to perfect the claim and they needed to decide the claim; (2) Harris had no opportunity to seek and submit responsive material during the claims process; (3) Standard had no opportunity to consider unknown responsive material because they deliberately closed off any such possibility; (4) the District Court had the opportunity to open and supplement the record but improperly decided not to; and (5) the Ninth Circuit generally cited Harris's on-point additional evidence but did not truly consider and weigh it as required by federal decisional law from this Court and below.

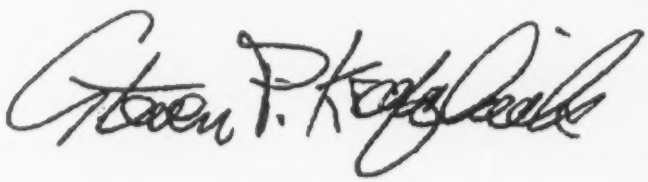
Here, the Court has a clear opportunity to rectify the lower courts' refusal to embrace ERISA's mandates. The Court should address this "perfect storm" of violations which the lower courts improperly allowed and continue to allow insurers to perpetrate on claimants, in direct violation of their higher-than-marketplace fiduciary duties.

CONCLUSION

The lower courts in this case failed to follow the ERISA statutes' and Department of Labor regulations' mandate for full and fair review at every level evaluating an ERISA plan administrator's adverse benefits determination. They failed to follow this Court's direction in *Glenn* that courts must consider and weigh "serious concerns" manifest in the conflict of interest inherent to dual-role plan administrators. Given the pressing issues presented here and the confusion manifest in the lower courts' misguided judicial review, this case merits certiorari.

For all these reasons, Petitioner Evelyn Harris prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,



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Supreme Court, U.S.
FILED
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No.

In The
Supreme Court of the United States

EVELYN S. HARRIS,

Petitioner

v.

THE STANDARD INSURANCE COMPANY and McNEES, WALLACE & NURICK WELFARE BENEFIT PLAN,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES
COURT OF APPEALS
FOR THE NINTH CIRCUIT

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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EVELYN S. HARRIS,
Plaintiff-Appellant, v.
STANDARD INSURANCE COMPANY; et al.,
Defendants-Appellees.

Nos. 08-35371

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MEMORANDUM*

March 25, 2009, Filed

NOT FOR PUBLICATION

COUNSEL: Steven P. Krafchick, Krafchick Law Firm, Seattle Washington, for Plaintiff-Appellant Evelyn S. Harris.

Katherine S. Somervell, Lisa E. Lear, Bullivant Houser Bailey PC, Portland, Oregon, for Defendants-

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Appellees Standard Insurance Company and McNees, Wallace, Nurick Welfare Benefit Plan.

Appeal from the United States District Court
For the District of Oregon
Paul J. Papak, Magistrate Judge, Presiding

Submitted March 2, 2009**
Portland, Oregon

Before: LEAVY, FISHER and M. SMITH, Circuit Judges.

Plaintiff-Appellant Evelyn Harris appeals the district court's grant of summary judgment to Defendants-Appellees Standard Insurance Company, et al. (Standard), in her case alleging wrongful denial of benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Because the parties are already familiar with the facts, we do not present them here except as necessary to explain our decision. We have jurisdiction pursuant to 28 U.S.C. § 1291, and we affirm the district court's ruling.

Under the terms of the contract between Harris and Standard, Standard had discretionary authority sufficient to warrant abuse of discretion review. *See Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965 (9th Cir. 2006) (en banc). Any procedural violations Standard may have committed do not amount to the "wholesale and flagrant violations"

** The panel unanimously finds this case suitable for decision without oral argument. *See* Fed. R. App. P. 34 (a)(2).

required for de novo review. *See id.* at 971. Therefore, the district court correctly reviewed Standard's decision for an abuse of discretion.

However, Standard did commit procedural violations by including new explanations for its denial of benefits in the "interim" denial letter of September 24, 2003, without giving Harris an opportunity to then submit additional evidence relevant to those explanations. *See Saffon v. Wells Fargo & Co.*, 522 F.3d 863, 871 (9th Cir. 2008) (holding final denial letter's reliance on the lack of evidence that the insurance company had not identified as necessary to successful disposition of the claim was a procedural violation denying claimant full and fair review); *Abatie*, 458 F.3d at 974 (holding "when an administrator tacks on a new reason for denying benefits in a final decision, thereby precluding the plan participant from responding to that rationale for denial at the administrative level" the administrator denies full and fair review). Accordingly, the district court should have weighed the violations as a factor in determining the level of skepticism to apply and considered Harris's additional evidence. *See id.* at 972-73 (holding procedural violations in processing a claim may require a more skeptical review and also may require the court to consider evidence outside the administrative record).

Nonetheless, we affirm because even viewing Standard's decision more skeptically and considering Harris' newly submitted evidence, Standard did not abuse its discretion in denying her claim. Harris submitted no contemporaneous medical evidence of

her inability to work for the entirety of the relevant six-month disability waiting period. In fact, she reported to her physician that she felt "100% better . . . better than she has felt in years," in the fifth month of the relevant period. Standard did not abuse its discretion in crediting the evidence presented by her physician over evidence Harris presented of her disability.

AFFIRMED.

**EVELYN S. HARRIS,
Plaintiff v. STANDARD
INSURANCE COMPANY
and McNEES, WALLACE &
NURICK WELFARE
BENEFIT PLAN,
Defendants.**

Nos. 06-1226 PK

**IN THE UNITED STATES
COURT FOR THE
DISTRICT OF OREGON**

ORDER

March 26, 2008, Filed

COUNSEL: Steven P. Krafchick, Krafchick Law Firm, Seattle, Washington, for Plaintiff Evelyn S. Harris.

Katherine S. Somervell, Bullivant Houser Bailey PC, Portland, Oregon, for Defendants Standard Insurance Company and McNees, Wallace, Nurick Welfare Benefit Plan.

BROWN, Judge.

Magistrate Judge Paul Papak issued Findings and Recommendation (#70) on January 28, 2008, in which he recommended the Court deny Plaintiff's Motion for Summary Judgment (#55), grant Defendants' Motion for Summary Judgment (#44), and dismiss this matter with prejudice. Plaintiff

filed Objections to the Findings and Recommendation. The matter is now before this Court pursuant to 28 U.S.C. § 636(b)(1) and Federal Rule of Civil Procedure 72(b).

When any party objects to any portion of the Magistrate Judge's Findings and Recommendation, the district court must make a *de novo* determination of that portion of the Magistrate Judge's report. 28 U.S.C. § 636(b)(1). *See also United States v. Reyna-Tapia*, 328 F.3d 1114, 1121 (9th Cir. 2003)(*en banc*); *United States v. Bernhardt*, 840 F.2d 1441, 1444 (9th Cir. 1988).

This Court has carefully considered Plaintiff's Objections and concludes they do not provide a basis to modify the Findings and Recommendation. The Court also has reviewed the pertinent portions of the record *de novo* and does not find any error in the Magistrate Judge's Findings and Recommendation.

CONCLUSION

The Court **ADOPTS** Magistrate Judge Papak's Findings and Recommendation (#70) and, therefore, **DENIES** Plaintiff's Motion for Summary Judgment (#55), **GRANTS** Defendants' Motion for Summary Judgment (#44), and **DISMISSES** this matter **with prejudice**.

IT IS SO ORDERED.

DATED this 26th day of March, 2008.

/s/ Anna J. Brown
ANNA J. BROWN,
United States District Judge

**EVELYN S. HARRIS,
Plaintiff v. STANDARD
INSURANCE COMPANY
and McNEES, WALLACE &
NURICK WELFARE
BENEFIT PLAN,
Defendants.**

Nos. 06-1226 PK

**IN THE UNITED STATES
DISTRICT COURT FOR
THE DISTRICT OF
OREGON**

**FINDINGS AND
RECOMMENDATION**

January 28, 2008, Filed

COUNSEL: Steven P. Krafchick, Krafchick Law Firm, Seattle, Washington, for Plaintiff Evelyn S. Harris.

Katherine S. Somervell, Bullivant Houser Bailey PC, Portland, Oregon, for Defendants Standard Insurance Company and McNees, Wallace, Nurick Welfare Benefit Plan.

PAPAK, Magistrate Judge:

This action was filed against defendants The Standard Insurance Company ("Standard") and McNees, Wallace & Nurick Welfare Benefit Plan (the "Plan") by plaintiff Evelyn S. Harris on May 16,

2007. Harris' complaint alleges improper denial of benefits and breach of fiduciary duty in violation of the Employee Retirement Income Security Act of 1974 ("ERISA"), and requests both monetary damages and equitable relief. This court has federal question jurisdiction over Harris' action pursuant to 28 U.S.C. § 1331, *see* 29 U.S.C. § 1132(a)(1)(B).

Now before the court are defendants' motion to strike (#62) extra-record evidence submitted by Harris in connection with the parties' cross-motions for summary judgment, defendants' motion for summary judgment (#44), and Harris' motion for summary judgment (#55). This court has considered the parties' motions, the pleadings on file, and oral argument on behalf of both parties. For the reasons set forth below, this court grants the motion to strike, recommends that defendants' motion for summary judgment be granted, and recommends that Harris' motion for summary judgment be denied.

LEGAL STANDARDS

I. Motion to Strike

The disposition of a motion to strike is within the discretion of the district court. *See Federal Say. & Loan Ins. Corp.* v. *Gemini Management*, 921 F.2d 241, 244 (9th Cit'. 1990). Motions to strike are disfavored and infrequently granted. *See Stabilisierungsjonds Fur Wein* v. *Kaiser, Stuhl Wind Distribs. Pty., Ltd.*, 647 F.2d 200, 201, 201 n.1 (D.C. Cir. 1981); *Pease & Curren Refining, Inc. v. Spectrolab, Inc.*, 744 F. Supp. 945, 947 (C.D. Cal.

1990), abrogated on other grounds by *Stanton Road Ass'n* v. *Lohrey Enters.*, 984 F.2d 1015 (9th Cir. 1993).

II. Summary Judgment

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). Summary judgment is not proper if material factual issues exist for trial. *See, e.g., Celotex Corp.* v. *Catrett*, 477 U.S. 318, 322 (1986); *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Warren v. City of Carlsbad*, 58 F.3d 439, 441 (9th Cir. *1995), cert. denied*, 116 S.Ct. 1261 (1996). In evaluating a motion for summary judgment, the district courts of the United States must draw all reasonable inferences in favor of the nonmoving party, and may neither make credibility determinations nor perform any weighing of the evidence. *See, e.g., Lytle v. Household Mfg., Inc.*, 494 U.S. 545, 554-55 (1990); *Reeves v. Sanderson Plumbing Products, Inc.*, 530 U.S. 133, 150 (2000).

FACTUAL BACKGROUND

Harris was employed as an attorney at the Pennsylvania-based law firm McNees Wallace & Nurick from March 1,200 I, to July 31,2002. While employed at McNees Wallace, she was a covered participant in the Plan, which provided long-term disability ("LTD") benefits pursuant to a group LTD

policy (the "Policy") issued by Standard, which also functions as the Plan's administrator.

The Policy defined being disabled from one's own occupation, in relevant part, as follows:

> You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:
>
> 1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and
>
> 2. You suffer a loss of at least 20% in your indexed Pre-disability Earnings when working in your Own Occupation.

A.R.090.[1] As an attorney, Harris was entitled under the Plan to LTD benefits for any period during which she was disabled from her own occupation, until she reached age 65, provided that she became disabled while covered under the Policy and that she remained continuously disabled for a period of 180 days (the "Benefits Waiting Period") following the onset of disability and prior to receiving LTD benefits.[2] *See* A.R. 095-094, 074.

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[1] Citations to the administrative record will use the designation "A.R," followed by the three digit Bates number corresponding to the referenced page of the record.

[2] The Policy provided that the Benefits Waiting Period could be interrupted by a period of up to 30 days during which a claimant could temporarily recover from a disabling condition without losing entitlement to LTD benefits or needing to begin a new Benefits Waiting Period, *see* A.R. 087-086, but the

On October 24, 2001, Harris began consulting a general practice physician, Megan Borror, in connection with moodiness and irritability problems that Harris reported as possibly related to perimenopause. *See* A.R. 327-328. Harris did not report pain symptoms during this visit, but did report fatigue symptoms in connection with the monthly onset of menses; she specified that she had been subject to such menstrual symptoms "always as far back as she can remember." *Id.* Dr. Borror prescribed FemHRT (a continuous combined hormone replacement therapy) to treat Harris' symptoms. *See id.*

At a follow-up appointment on December 10, 2001, Harris reported that all of her reported symptoms, plus depression, were now under control. *See* A.R. 328. Four days later, however, Harris called Borror's office reporting intermittent episodes of depression symptoms, for which she was prescribed Effexor. *See* A.R. 329. On December 18, 2001, Harris again visited Borror's office, and reported that her depression symptoms were improved. *See id.* According to Borror's notes:

> [Harris] is able to concentrate on work, no longer having significant mood swings, irritability. She had difficulty at work when she would look at her workload and get physically sick to her stomach, and feel energy drain. This

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applicability of the temporary recovery provision was not raised in the briefs of either party in support of the summary judgment motions now before the court. This court therefore will not consider the affect, if any, of the temporary recovery provision in analyzing the parties' motions.

> is no longer happening. She gets through work day fine, libido improved. Appetite fine.

Id. On February 28, 2002, Harris again reported to Borror that "things were better, [and that she] no longer had significant mood swings or irritability." *See* A.R. 330. However, on May 22, 2002, Harris reported to Borror that for the three previous weeks she had again experienced problems with "decreased energy, [and a] sense of being tired, [of] not having energy to get out of [her] chair. Low ambition, no drive. Feels empty and hollow inside but does not feel hungry." *Id.* She also reported pain symptoms for the first time, indicating that she first noticed the symptoms after working in her garden. *See id.* She experienced the pain in her back, but also, at least some of the time, in the left side of her face. *See id.* Borror advised Harris to reduce her alcohol consumption and to change the time of day she took her Effexor. *See* A.R. 331.

In a series of telephone calls and office visits in early June 2002, Harris reported to Borror that her problems at work were continuing, as were her nausea and "no energy" symptoms. *See id.* Borror prescribed Lorazepam. *See id.* Harris took one dose of the new medication, fell asleep at work, and discontinued its use immediately thereafter. *See* A.R. 332.

On June 17, 2002, Harris reported that her fatigue was still a problem, although somewhat improved, and that she still felt decreased energy and loss of ambition. *See id.* She also reported a high incidence in errors when dictating letters, and in choice of words when speaking, which she attributed

to Effexor. *See id.* Borror advised Harris to taper off the Effexor, and begin taking Zoloft instead. *See id.*

Borror's prescribed treatments proved ineffective, and, in consequence of her fatigue symptoms, Harris stopped working at McNees, Wallace & Nurick. Her last full day of work was June 28, 2002, *see* A.R. 199, although her employment (and therefore her coverage under the Policy) did not terminate until July 31, 2002, *see* A.R. 105. Pursuant to the Policy, Harris is therefore entitled to LTD benefits if she became disabled from her occupation as an attorney on any date from June 28 to July 31, 2002, and thereafter remained continuously disabled for a period of 180 days.

In August 2002 Borror consulted with internist John Nipple, seeking an alternative medical opinion as to the nature of her condition. *See* A.R. 332-333. Dr. Nipple conducted extensive laboratory tests on Harris, all of which produced results within the normal range, other than a low level of vitamin B12. *See id.* Nipple prescribed monthly BI2 shots. *See id.*

On September 26, 2002, Harris reported to Borror that she felt significantly better since leaving work, but that she still had problems with tiring easily. *See* A.R. 333. Moreover, although she felt better, she reported spending two days in bed following a visit to her former workplace to retrieve personal belongings. *See id.* Borror concluded that Harris was suffering residual depression, although she noted that Harris' condition and affect were markedly improved over her most recent previous office visit. *See id.*

On November 5, 2002, in the course of a scheduled appointment to monitor the efficacy of Harris' depression treatment, Harris reported to Borror that she was "100% better, [and that she] fe[lt] better than she ha[d] felt in years." *See* A.R. 335. She reported that she "enjoy[ed] being off, taking care of home, re-acquainting herself [with her] sisters and mother and spending time with them." *Id.* In addition, Harris "found improvement in all areas of life including mood, sleep, libido, etc." *Id.* Borror concluded that Harris' "adjustment disorder, depressed mood, [were] much better since leaving job[;] I think she made big turnaround." *Id.*

On December 18, 2002, Harris requested that Borror fax all of her medical records to Dr. Jacob Teitelbaum, a specialist in chronic fatigue syndrome. *See* A.R. 334. Harris met with Dr. Teitelbaum on December 23, 2002. *See* A.R. 275. At the conclusion of that meeting, Teitelbaum made a primary diagnosis of myofascial pain syndrome, and a secondary diagnosis of chronic fatigue syndrome, as well as hypothalamic dysfunction with accompanying neuroendocrine immune dysfunction, and noted symptoms of severe insomnia, widespread severe pain, cognitive dysfunction, and severe fatigue and exhaustion, among others. *See* A.R. 196. Teitelbaum concluded that Harris was "100% disabled." A.R. 459.

On January 25, 2003, Harris applied for LTD benefits. *See* A.R. 197. Her application described her illness as "Chronic Fatigue and Immune Dysfunction

Syndrome Fibromyalgia[3]" and her symptoms as "Fatigue and Chronic Pain, Reduced Ability to Concentrate." *See* A.R. 199. The application did not reference any additional disabling condition or symptoms. *See id.* Standard referred Harris' application to consulting rheumatologist Shirley Ingram.

In a report dated April 8, 2003, Dr. Ingram opined that as of November 5, 2002, Harris could reasonably have returned to work as an attorney, based on Harris' self-report of her condition at that time. *See* A.R. 347. In addition, Ingram opined that Harris' medical records supported Borror's diagnosis of depression rather than Teitelbaum's diagnosis of chronic fatigue syndrome, based in part on Harris' reported symptoms and her responsiveness to depression treatment, and in part on what she concluded were flaws in Teitelbaum's diagnostic methods, including Teitelbaum's failure to rule out depression as a cause of Harris' symptoms. *See id.* Ingram also noted that Teitelbaum never diagnosed Harris with fibromyalgia, and further noted the absence of significant pain symptoms recorded in Harris' medical records other than one instance reported as related to gardening. *See id.* Ingram also opined that Teitelbaum's plan to follow up with Harris for the first time in May 2003, five months following his single meeting with her, was inconsistent with the nature of his diagnosis. *See id.*

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[3] As noted above, Teitelbaum diagnosed myofascial pain syndrome rather than fibromyalgia. Indeed, Teitelbaum specifically rejected a fibromyalgia diagnosis, noting that Harris did not have symptoms necessary to support such a diagnosis.

Ingram recommended that Standard obtain psychiatric or neurocognitive testing records if any such testing had been performed. *See id.*

Subsequently, by letter dated April 25, 2003, Standard denied Harris' application for benefits. *See* A.R. 362-355. Standard's letter set forth each of Ingram's conclusions and concerns, but did not specifically request that Harris provide psychiatric or neurocognitive testing records if such testing had been performed. *See id.* Instead, Standard advised Harris that she had 180 days within which to request review of its decision, and that she could include additional material along with any such request. *See* A.R. 356. Standard's letter specified that such additional information could helpfully include "medical records or chart notes indicating that your medical condition is more severe than we previously understood and continues to support your inability to perform the material duties of your own occupation throughout the 180 day benefit waiting period." *Id.* The letter specified that Standard's review would be conducted by claims specialists not involved in the initial decision to deny benefits. *See id.*

On July 21, 2003, by a letter drafted and signed by her husband, Harris appealed Standard's decision. *See* A.R. 463-461. With her appeal, Harris included a letter from Teitelbaum reiterating his prior diagnosis, and new medical files from Drs. Shashikant B. Patel and Nita Rastogi. Dr. Patel had seen Harris on February 27, 2003, in connection with "mild macrocytic anemia," for which he recommended that Harris abstain from alcohol. *See*

A.R. 412-409. Patel noted that Harris had been diagnosed with chronic fatigue syndrome with onset in October 2001, but did not independently arrive at this diagnosis. *See id.* By contrast, Dr. Rastogi appears to have independently assessed Harris' reported symptoms as consistent with chronic fatigue syndrome, hemochromatosis, and fibromyalgia as of March 25, 2003, although her own testing did not uncover any data in support of such a diagnosis. *See* A.R. 404.

Apparently because the letter requesting review suggested Standard's bad faith or procedural irregularity in reaching its initial decision, the new information offered by Harris was first considered by the same claims specialist and consulting physician who had first decided to deny Harris' application. They concluded that nothing in the new information changed their initial evaluation, and therefore forwarded the entire file to Standard's "Quality Assurance Unit" for independent review, advising Harris they were so doing by letter dated September 24, 2005. *See* A.R. 505-499.

Standard's letter of September 2005 reiterated that Teitelbaum's medical records did not support a diagnosis of fibromyalgia, and further asserted that Teitelbaum's methodology was at odds with standard rheumatologic evaluation and unsupported by standard scientific reasoning, and that his treatment regimen was not generally accepted within the medical community. *See* A.R. 501, 500. Standard asserted, moreover, that even if a diagnosis of any pain syndrome were well supported by the available medical records, such a diagnosis would not

ordinarily disable someone from a sedentary to light-level occupation. *See* A.R. 500. The letter additionally reiterated that chronic fatigue syndrome is a diagnosis of exclusion, and therefore an untenable diagnosis in the presence of indicators of depression. *See* A.R. 501. The September letter, unlike the April letter, also expressly noted the absence of any neuropsychiatric evaluations or other documentation of cognitive impairment in any of the records submitted by Harris. *See* A.R.500.

A new claims specialist reviewed the file on appeal, in consultation with internist Bradley Fancher. In a report dated October 2, 2003, Dr. Fancher reviewed Harris' medical history and issued a conclusion consistent with that previously reached by Ingram. *See* A.R. 533-528. Fancher opined that Teitelbaum's treatment regimen was "without any scientific merit," labeled him "unorthodox," and criticized his failures to document any review of Harris' medical records, to perform a mental health history or examination, to perform cognitive testing, or to document any cognitive dysfunction. A.R. 531. Fancher cited "numerous and easy to identify" methodological flaws in Teitelbaum's publications, and opined that they would not have been published in orthodox peer-reviewed medical journals. A.R. 530. Fancher also noted that Patel and Rastogi's respective physical examinations of Harris were "unremarkable." *Id.* Fancher opined that Harris' medical records supported a diagnosis of adjustment disorder associated with depression, and that her condition would not have been disabling continuously through the applicable benefits waiting period. *See* A.R. 529. In support of this opinion,

Fancher found Borror's chart note of November 5, 2002, "remarkable." *Id.*

On October 23, 2003, Standard advised Harris by letter of its final decision to deny her application. *See* A.R. 563-553. The October letter explained the reasons for Standard's conclusion that Harris did not have fibromyalgia, and further explained that fibromylagia and other pain syndromes do not disable a person from performing sedentary to light-level occupations such as that of attorney. *See* A.R. 561-560. The letter also explained that a diagnosis of depression or of adjustment disorder, which could account for fatigue symptoms, precluded a diagnosis of chronic fatigue syndrome, and concluded that, in light of Borror's November 5, 2002, chart note documenting Harris' self-report of improvement, her fatigue symptoms had not been continuously disabling throughout the benefits waiting period.4 *See* A.R. 558-557.[4]

In its October letter, Standard advised Harris of her right to receive copies of documents in her claim file without charge, and of her right to file suit against Standard in the event she disagreed with its decision. *See* A.R. 554. This action followed.

ANALYSIS

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[4] The October letter further opined that, if Teitelbaum's opinion that Harris was" 100% disabled" due to pain and fatigue as of December 23, 2002, was correct, that such disability was not due to the same cause as the adjustment disorder/depression that caused Harris to cease work in June 2002, and that therefore the temporary recovery provision of the Policy was inapplicable.

I. Applicable Standard of Review

This court reviews an ERISA plan's denial of ERISA benefits *de novo,* except where the administrator properly exercises discretionary authority to interpret plan terms and to make final benefits determinations, in which case the denial is reviewed for abuse of discretion only:

> [A] denial of benefits challenged under §1132(a)(l)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan [in which case the abuse of discretion standard applies] ....Thus, for purposes of actions under §1132(a)(l)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest.

Firestone Tire & Rubber Co. v. *Bruch,* 489 U.S. 101, 115 (1989) (citation, internal quotation marks and modifications omitted).

The Policy at issue here provides that:

> Except for those functions which the Group Policy specifically reserves to the Policy owner or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group

> Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. A.R. 076.

Under applicable Ninth Circuit jurisprudence, this language is effective to confer discretion on a plan administrator. *See Bendixen* v. *Standard Ins. Co.*, 185 F.3d 939, 943 (9th. Cir. 1999); *see also Abatie* v. *Alta Health & Life Ins. Co.*, 458 F.3d 955, 963-964 (9th Cir. 2006) *(en banc)*. However, before concluding that abuse of discretion is the appropriate standard of review, this court must first consider the nature and impact of Standard's procedural irregularities, if any. In addition, if abuse of discretion is the appropriate standard, this court must determine the appropriate level of skepticism to apply in light of any conflict of interest applicable to Standard.

For the following reasons, this court concludes that Standard committed no procedural errors in processing Harris' claim, and thus that its decision to deny Harris benefits may be reviewed for abuse of discretion only. The court further concludes that, in light of Standard's structural conflict of interest, its benefits decision must be viewed with a cognizable but low level of skepticism.

A. Procedural Irregularities

Even where a plan confers discretion on a plan administrator, when the administrator commits "wholesale and flagrant" procedural violations in connection with a denial of benefits, the Courts

apply a *de novo* standard in reviewing the administrator's decision:

> **When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review *de novo* the administrator's decision to deny benefits**. We do so because, under *Firestone,* a plan administrator's decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract. 489 U.S. at 111. *Firestone* directs, consistent with trust law principles, that "a deferential standard of review [is appropriate when a trustee *exercises* discretionary powers." *Id.* (emphasis added). Because an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority.
>
> In general, we review *de novo* a claim for benefits when an administrator fails to exercise discretion.

Abatie, 458 F.3d at 972 (bolded emphasis supplied, modifications original).

Procedural violations that are less than "wholesale and flagrant," by contrast, do not trigger *de novo* review. Nevertheless, such irregularities

constitute a factor in determining whether a plan administrator abused its discretion:

> As noted, a procedural irregularity in processing an ERISA claim does not usually justify *de novo* review. That generalization does not mean, however, that procedural irregularities are irrelevant to the court's analysis.
>
> A procedural irregularity ... is a matter to be weighed in deciding whether an administrator's decision was an abuse of discretion. When an administrator can show that it has engaged in an ongoing, good faith exchange of information between the administrator and the claimant, the court should give the administrator's decision broad deference notwithstanding a minor irregularity. A more serious procedural irregularity may weigh more heavily.

Abatie, 458 F .3d at 972 (citations, internal quotation marks omitted).

Moreover, where such irregularities prevent a claimant from fully developing the administrative record, the court must permit the claimant to present additional evidence that could have been submitted absent the procedural defalcation. *See id.* at 972-973. "In that way the court may, in essence, recreate what the administrative record would have been had the procedure been correct." *Id.* at 973. In the event such newly submitted evidence is significant, as a practical matter *de novo* review will be required despite a plan's conferral of discretion, in

that the administrator's decision will necessarily have been made without the benefit of all relevant evidence. *See Saffon* v. *Wells Fargo & Co. Long Term Disability Plan*, 2008 U.S. App. LEXIS 334, 24-25 (9th Cir. 2008).

Here, Harris argues that in processing her claim Standard committed wholesale and flagrant procedural errors justifying *de novo* review; in the alternative, Harris argues that the alleged errors prevented full development of the record, opening the door to submission of significant extra-record evidence, similarly requiring *de novo* review. For their part, defendants argue that Standard committed no procedural errors, neither wholesale and flagrant nor otherwise.

For the following reasons, this court finds that defendants are correct: Standard complied with the procedural requirements established by Congress for ERISA plan administrators in connection with the denial of benefits, and therefore committed no procedural irregularity.

1. 29 C.F.R. 2560.503-1(J)(3)

Harris' first assignment of error is that Standard violated a notification requirement under 29 C.F.R. 2560.503-1(j)(3). Harris argues, specifically, that she did not receive the required notification until after Standard had already denied her claim and it was too late for her to develop the administrative record further.

ERISA plans are required to "establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination." 29 C.F.R. 2560.503-1 (h)(1). Following such review, plans are required to provide claimants with written or electronic notification of the plan's review determination. *See* 29 C.F .R. 2560.503-1(j). Such notification must "set forth, in a manner calculated to be understood by the claimant," among other things, "a statement that a claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." 29 C.F.R. 2560.503-1(j)(3).

Harris concedes that Standard's letter of October 23, 2003, contained a compliant notification statement following Standard's review on appeal of its decision to deny benefits. However, Harris argues that Standard's letter of September 24, 2003, which did not contain such a statement, also constituted a notification of the Plan's review determination, and that the failure to advise Harris of her right to a copy of the administrative record in that letter was in violation of Section 503-1 (j)(3).

Harris' argument is unpersuasive. Standard's September 2003 letter followed consideration by the same claims specialist who made the initial benefits determination of new evidence Harris submitted in connection with her request for review, but expressly

preceded the review procedure required by the Code of Federal Regulations. Because the September letter did not follow the "full and fair review" of the adverse benefits determination by "an appropriate named fiduciary of the plan" provided for in Section 503-1 (h)(I), it did not trigger the requirements of Section 503-1 (j). Standard was not required to issue the Section 503-1 (j)(3) notification statement in *advance* of the statutorily prescribed review, and therefore did not violate its procedural requirements by failing to do so.

2. 29 C.F.R. 2560.503-1(g)

Harris' second assignment of error is that Standard's first two letters, respectively dated April 25 and September 24, 2003, failed to identify adequately the additional materials and information that Harris would have needed to submit in order to prove her entitlement to benefits. Specifically, Harris points to Standard's failure in its April 2003 letter to flag the absence of psychiatric or neurocognitive testing records from Harris' submitted materials and the alleged vagueness of Standard's description of additional materials that could be helpfully submitted.

ERISA plan administrators are required pursuant to 29 C.F .R. 2560.503-1(g) to provide claimants with "written or electronic notification of any adverse benefit determination." 29 C.F.R. 2560.503-1(g)(1). Such notifications must "set forth, in a manner calculated to be understood by the claimant," among other things, "[a description of any additional material or information necessary for the

claimant to perfect the claim and an explanation of why such material or information is necessary." *Id.* This mandate must be read in light of the holding in *Booton* v. *Lockheed Medical Benefit Plan,* 110 F.3d 1461 (9th Cir. 1997), that "what this regulation[5] calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries." *Booton,* 110 F.3d at 1463. The *Booton* court illustrated its point with the plain-English injunction that "if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it." *Id.*

More recently, in *Saffon, supra,* the Ninth Circuit provided additional guidance as to how a plan administrator should conduct the "meaningful dialogue" required by Section 503-1(g). *Saffon,* 2008 U.S. App. LEXIS 334 at 14. The *Saffon* court decried the obfuscatory language of the plan administrator's communications with its beneficiary, which was in crucial places both semantically empty and syntactically unparsable. The court further took the plan administrator to task for failing to explain why the claimant's medical records did not support a finding of disability, for noting the absence of critical diagnostic testing only in its final communication with the claimant, for patently illogical medical reasoning, for apparently willful misinterpretation of the available medical evidence, and for communicating with the claimant's treating physicians (and setting arbitrary deadlines for the

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[5] The *Booton* holding addressed a substantially identical predecessor regulation to Section 503-1 (g).

physicians' responses) without the claimant's knowledge or consent. *See id.* at 14-20.

Here, Standard's communications with Harris, while occasionally agrammatical, were nevertheless reasonably comprehensible. In each of its letters, Standard was at pains to explain in detail the basis for its disagreement with Teitelbaum's diagnosis. Standard's letters indicate that Harris' medical records were reviewed thoroughly, and without distortion of the evidence they contained. Standard did not attempt to contact Harris' treating physicians without her knowledge.

It is troubling, however, that Standard did not act on Ingram's recommendation to obtain records of any psychiatric or neurocognitive tests, if any such testing had been performed, in its April 2003 letter. As Harris argues, had she been made aware in advance of requesting review that psychiatric or neurocognitive testing might have uncovered evidence in support of her claim, she might have obtained such testing before Standard's final benefits denial issued. Nevertheless, Standard's failure to specifically advise Harris that psychiatric or neurocognitive testing could potentially bolster her claim does not amount to a procedural violation.

First, Standard was not required to provide an exhaustive list of every possible piece of medical evidence that could conceivably strengthen Harris' application; rather, the regulations required Standard to advise Harris of what additional information it needed to intelligently evaluate Harris' claim. That Standard stated that "additional

information, which would be helpful to a reconsideration of your claim, includes medical records or chart notes indicating that your medical condition is more severe than we previously understood and continues to support your inability to perform the material duties of your own occupation throughout the 180 day benefit waiting period" in *general* terms does not render its statement impermissibly *vague*. Indeed, increased specificity would likely have been misleading, in that the absence of psychiatric or neurocognitive testing was not ultimately critical to Standard's decision. Had Harris been specifically advised that such testing might strengthen her application, she might have focused her efforts on obtaining those tests to the exclusion of other medical information of comparable or greater importance. Instead, Standard requested in plain English the additional information that was needed: *any* medical records tending to support the conclusion that her medical condition was more severe than indicated by the evidence already available.

Second, unlike the plan administrator in *Saffon*, Standard did advise Harris that some degree of weight was being placed on the absence of evidence of cognitive dysfunction in her available medical records in advance of the final benefits decision. Harris was put on notice of the absence of such evidence by Standard's letter of September 2003, which preceded Standard's statutorily mandated "full and fair review" of her claim. Unlike the *Saffon* plaintiff, Harris therefore had an opportunity, of which she did not avail herself, to further

supplement and develop the administrative record before the final benefits decision was made.

Third and finally, as noted above, the absence of evidence of cognitive deficits was merely one datum among many noted by Standard's physician consultants. More critical to both the initial decision and the decision on review were the facts that pain syndromes are not considered disabling with respect to sedentary or light-level occupations and that Harris appeared to be free of fatigue symptoms before the end of the I80-day benefits waiting period. Neither Standard's letters nor the reports of the consulting physicians suggest that psychiatric or neurocognitive testing might have significantly modified the conclusions Standard drew from these facts.

Because Standard's letters to Harris were compliant with 29 C.F.R. 2560.503-1(g), defendants committed no procedural irregularity in their description of additional information that might helpfully have been submitted in connection with Harris' request for review.

3. Misleading Reference

Harris suggests that Standard may have committed procedural errors by misleadingly referring to the Policy definition of disability from *any* occupation in its letter to Harris dated April 25, 2003. In fact, although the letter did quote in full the Policy definition of disability, including disability from any occupation, the letter clearly specified that to be entitled to benefits Harris needed only to meet

the definition of disability from her *own* occupation, and thereafter referred specifically to "own occupation" disability only. It was therefore neither procedurally irregular nor misleading to quote the disability definition in full.

B. Conflict of Interest

It is well settled that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion." *Firestone,* 489 U.S. at 115. That is, *Firestone* requires "abuse of discretion review whenever an ERISA plan grants discretion to the plan administrator, but a review informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record." *Abatie,* 458 F.3d at 967. "This standard applies to the kind of inherent conflict that exists when a plan administrator both administers the plan and funds it, as well as to other forms of conflict." *Id.* Under *Abatie,* the courts of the Ninth Circuit applying the abuse of discretion standard to denials of ERISA benefits review conflict of interest allegations on a case by case basis, applying a level of skepticism appropriate to the egregiousness of the particular conflict of interest and of the indicia that it may have tainted the administrator's decision. *See Abatie,* 458 F.3d at 968-969. Specifically, the *Abatie* court held that:

> The level of skepticism with which a court views a conflicted administrator's decision may be low if a structural conflict of interest is unaccompanied, for example, by any evidence of

> malice, of self-dealing, or of a parsimonious claims-granting history. A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial, fails adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit a claimant's reliable evidence, or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record.

Id. (citations omitted)

Here, all parties agree that Standard operates under a structural conflict of interest, in that it both decides whether or not claimants will receive benefits and is the party responsible for paying benefits when they are awarded. Such a conflict of interest necessarily creates a serious risk of biased decision making by plan administrators, and is not to be treated lightly even absent additional aggravating factors.

In connection with Standard's conflict of interest, Harris offers evidence that Standard assigned claims filed by claimants with pre-disability monthly earnings in excess of $10,000 (such as Harris) to a special unit, known as the "C team," for processing, evidence that the physician who consulted with Standard in connection with its review of Harris' claim on appeal was compensated at $130 per hour for his work with Standard, and evidence that, at the time Harris' claim was processed, Standard had a bonus system in place whereby Standard's employees could become entitled to money bonuses

under circumstances unspecified in either the offered evidence or the parties' briefing. Harris does not, however, offer evidence of Standard's malice, self-dealing, history of denying meritorious claims, or history of misinterpreting policy terms or disregarding medical evidence, nor does she offer evidence that the "C team" employed any different standard in processing claims than Standard's other employees used in processing claims of lesser monetary value. Moreover, the evidence in the record does not support any conclusion that Standard gave inconsistent reasons for its denial of Harris' claim, that it failed to investigate her claim or to ask her for necessary evidence, or that it failed to credit competent medical evidence in the record.

In light of the evidence before the court, including evidence outside the administrative record submitted for the express purpose of demonstrating the extent of Standard's conflicted decision-making, Standard's conflict of interest merits only a "low" level of skepticism. *See Abatie*, 458 F.3d at 967,968-969.

II. Motion to Strike

As noted above, Harris argues that Standard's alleged procedural irregularities prevented her from fully developing the administrative record and that, under *Abatie*, she is therefore entitled to supplement the record to the same extent that the alleged defalcations prevented its full development. On this basis, Harris now offers the following extra-record documents: a neuropsychological examination and evaluation prepared by Dr. Curt Sandman in

September 2007, and the declarations of Harris, of her husband, and of Teitelbaum. Defendants move to strike these documents, on the ground that this court may not consider evidence outside the record in reviewing the merits of Standard's benefits decision. For the following reasons, this court agrees with defendants, and grants the motion to strike.

On *de novo* review of an ERISA plan's denial of benefits, the district courts have discretion to consider any evidence offered by the parties, but under an abuse of discretion standard, the courts are generally limited to review of the administrative record. *See, e.g., Jebian* v. *Hewlett-Packard Co. Empie. Benefits Org. Income Prot. Plan,* 349 F.3d 1098, 1110 (9th Cir. 2003). One exception to this general rule arises where a plan administrator operates under a conflict of interest. Under that circumstance, the courts may consider evidence outside the record in connection with establishing the extent an administrator's conflict of interest *only* (review of the merits of the administrator's decision must still rest wholly on evidence within the administrative record, even where a conflict of interest is established):

> The district court may, in its discretion, consider evidence outside the administrative record to decide the nature, extent, and effect on the decision-making process of any conflict of interest; the decision on the merits, though, must rest on the administrative record once the conflict (if any) has been established, by extrinsic evidence or otherwise.

Abatie, 458 F.3d at 970. The evidence that Harris now offers goes strictly to the merits of Standard's benefits decision rather than to establishing conflict of interest, and therefore cannot be admitted pursuant to *Abatie's* conflict of interest exception.

As noted above, however, where a plan has committed procedural irregularities the courts may consider evidence outside the administrative record to supplement gaps in the record caused by the procedural defalcations. *See Abatie*, 458 F.3d at 972-973. In this case, for reasons set forth above, the court has concluded that Standard complied with all applicable procedural requirements. Harris therefore may not offer extra-record evidence pursuant to *Abatie's* procedural irregularity exception. This court's review must necessarily be limited to the administrative record, and the extra-record materials submitted by Harris are properly strickenfrom the record.

III. The Parties' Cross-Motions for Summary Judgment

As noted above, Harris' complaint articulates three claims, styled as claims for recovery of benefits, for breach of fiduciary duty, and for equitable relief; properly speaking, the third "claim" is a request for relief premised on defendants' liability for at least one of the other two claims. Now before the court are the parties' cross-motions styled as motions for summary judgment, each of which expressly addresses the merits of the recovery of benefits claim and fails to address either of the other two claims raised in Harris' complaint. Because Harris' counsel conceded at oral argument that his

client's breach of fiduciary duty claim would not be viable in the event the recovery of benefits claim was dismissed, this court will treat defendants' motion as a motion for summary judgment as to all of Harris' claims, and Harris' motion as a motion for partial summary judgment as to the recovery of benefits claim only.

Also as noted above, this court's review, to be conducted with all due skepticism in light of Standard's structural conflict of interest, is for abuse of discretion only. "An abuse of discretion is found only when there is a definite conviction that the [decision-maker] made a clear error of judgment in its conclusion upon weighing relevant factors." *Hummell* v. *SE. Rykoff & Co.*, 634 F.2d 446, 452 (9th Cir. 1980); *see also Oster* v. *Barco of Cal. Employees' Retirement Pian*, 869 F.2d 1215, 1218 (9th Cir. 1988) (no abuse of discretion by an ERISA administrator unless the decision is "so patently arbitrary and unreasonable as to lack foundation in factual basis").

Here, Standard's decision to deny benefits was neither clearly in error nor unreasonable, was based on review of all available evidence, and was substantially supported by evidence in the record. Specifically, Standard could reasonably have concluded, based on Harris' self-report of significant improvement and Borror's medical opinion that Harris' adjustment disorder had undergone a "big turnaround" in November 2002, that Harris' fatigue symptoms had improved to the point that she was no longer disabled from her occupation before the end of the benefits waiting period. Standard could

reasonably have further concluded, based on evidence in the record, that Harris' pain symptoms were not sufficiently severe to be disabling with regard to employment as an attorney. Moreover, reasonable medical professionals could disagree as to the accuracy of Teitelbaum's diagnoses and conclusion that Harris was disabled by myofascial pain syndrome and chronic fatigue syndrome, as evidenced by the fact that Borror, Harris' treating physician of many years, did not share in them.

In addition, although this court views the reports drafted by Ingram and Fancher with all due skepticism, Standard's consulting physicians opined persuasively that Teitelbaum's methodologies, diagnoses, and treatment regimens were flawed and untrustworthy. Even viewing Standard's exercise of discretion as skeptically as permitted by applicable law, this court cannot conclude that Standard abused its discretion by concluding that Teitelbaum's conclusions were inaccurate. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003) ("courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation"); *see also id.* at 832 ("the assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration .... And if a consultant engaged by a plan may have an incentive'

to make a finding of 'not disabled,' so a treating physician, in a close case, may favor a finding of 'disabled').

The existence of evidence in the record that would have supported a contrary conclusion is not evidence of abuse of discretion. *See, e.g., Taft v. Equitable Life Assurance SOC,* 9 F.3d 1469,1473-1474 (9th Cir. 1993) ("In the ERISA context, even decisions directly contrary to evidence in the record do not necessarily amount to abuse of discretion"); *Bolling v. Eli Lilly & Co.,* 990 F.2d 1028, 1029-30 (8th Cir. 1993) ("The [administrator] did not abuse its discretion merely because there was evidence before it that would have supported an opposite decision"), *cited with approval by Taft,* 9 F.3d at 1474; *Sandoval v. Aetna Life & Casualty Ins. Co., 967* F.2d 377, 382 (10th Cir. 1992) (determination that claimant was not disabled was supported by "substantial evidence" and the administrator's decision was therefore not an abuse of discretion where one doctor's report concluded the claimant was disabled and the other did not), *cited with approval by Taft,* 9 F.3d at 1474; *see also Anderson v. Operative Plasterers' & Cement Masons' Int'l Ass'n,* 991 F.2d 356, 358-59 (7th Cir. 1993) (not abuse of discretion to deny benefits despite previous finding of disability by social security board), *cited with approval by Taft,* 9 F.3d at 1474. Because there was a factual basis in the record to support Standard's decision, and because Standard's decision was reasonable in light of that factual basis, this court must conclude that Standard did not abuse its discretion in denying benefits to Harris.

Because Standard was within its discretion to deny Harris' application for LTD benefits, her recovery of benefits claim necessarily fails. Harris' motion for partial summary judgment should therefore be denied in its entirety. Because Harris has conceded through her counsel that her remaining claims are nonviable in the event her recovery for benefits claim is dismissed, defendants' motion for summary judgment should be granted as to all of Harris' claims.

CONCLUSION

For the reasons set forth above, this court grants defendants' motion to strike (#62), recommends that Harris' motion for summary judgment (#55) be denied, and recommends that defendants' motion for summary judgment (#44) be granted as to each of Harris' claims. A judgment should be prepared dismissing Harris' claims with prejudice.

SCHEDULING ORDER

The above Findings and Recommendation will be referred to a United States District Judge for review. Objections, if any, are due February 11, 2008. If no objections are filed, review of the Findings and Recommendation will go under advisement on that date. If objections are filed, a response to the objections is due fourteen days after the date the objections are filed and the review of the Findings

and Recommendation will go under advisement on that date.

Dated this 28th day of January, 2008.

/s/ Paul Papak
Honorable Paul Papak
United States Magistrate Judge

Title 29, Code of Federal Regulations, Section 2560-503-1(g)(1) . . . [T]he plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . . . The notification shall set forth, in a manner calculated to be understood by the claimant—**(iii)** A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

Title 29, Code of Federal Regulations, Section 2560-503-1(h)(1)-(4):

(h) Appeal of adverse benefit determinations. (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

* * *

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other

information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) . . . (i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's

adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual . . . .

(4) Plan providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(1) through (v) of this section.

Title 29, Code of Federal Regulations, Section 2560-503-1(i)(5): Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

Title 29, Code of Federal Regulations, Section 2560-503-1(j): Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review . . . . In the case of an adverse benefit determination, the notification shall

set forth, in a manner calculated to be understood by the claimant—

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(4): The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Title 29, Code of Federal Regulations, Section 2560-503-1(m)(8): A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information

EXCERPTS OF RESPONDENT STANDARD INSURANCE COMPANY'S DENIAL LETTER DATED April 25, 2003 (9th Circuit ER 363-370)

Dear Ms. Harris:

...

On your following office visit of November 5, 2002, Dr. Borror noted that in regards to your depression, you reported feeling "100% better, feels better than she has felt in years". Dr. Borror further noted that the increase to your Zoloft has helped, you had no problem with your appetite or stomach, and you were enjoying life. Your weight was 109 ¾ pounds and you were noted as being alert and with a bright affect. The assessment was that you were much better since leaving your job. Your Zoloft was continued and you planed on returning to see Dr. Borror in three months.

...

Upon review of the available medical documentation, the physician consultant opined that if you were really taking most the medications as described above, you indeed would be at great risk for drug interaction and oversedation. This raises the possibility that these medications may have contributed to your sedated state, possibly contributing to your fall down the stairs and the noticeable slurred speech the ENT PA Ms. Bentz noted. Furthermore, the physician consultant opined that your elevated MCV could be an indication of alcohol overuse. Also, the diagnosis of

chronic fatigue syndrome is a diagnosis of exclusion and it is agreed upon in the general medical community that it is not a tenable diagnosis in the presence of depression, which symptoms are identical.

Additionally, the diagnosis of Fibromyalgia is not documented in the available medical records. Although you have had complaints of musculoskeletal pains, a musculoskeletal examination that documents the typical tender points is absent from the records. Furthermore, there are minimal to no musculoskeletal complaints at the time you ceased work except for your complaint of back pain related to prior gardening.

The physician consultant concluded that the available medical records support the diagnosis of depression for which you received appropriate treatment from Dr. Borror and was markedly improved in the fall of 2002, as one would expect within two to three months of an appropriate antidepressant medication. The usual treatment also is a psychiatric consultation particularly if there is a relapse or no response to medication. Therefore, as of your visit with Dr. Borror's in November of 2002, it would have been reasonable for you to have been able to return to your Own Occupation as an Attorney. The ENT note from February of 2003 does document your fall and slurred speech but there is no medical assessment that would lead to a conclusion of a limitation or restriction from work except for week following the injury. While we cannot exclude that you could be impaired from the medications that Dr. Teitelbaum has prescribed, we

note he does not plan to see you again until May of 2003. This is not consistent with an ongoing medical problem causing physical and/or mental limitations and restrictions.

After a complete review of your claim file, including your statements and the results from the medical file review, we find that as of November 2002 your depression had markedly improved, given your appropriate treatment from antidepressant medications as noted by Dr. Borror. Although Dr. Teitelbaum diagnosed you with Chronic Fatigue Syndrome and Myofa[s]cial Pain Syndrome in December of 2002, review of the available medical records does not support this diagnosis. Furthermore, the length of time between your visits with Dr. Teitelbaum's is not consistent with severe ongoing limitations and restrictions. Lastly, your fall in February of 2003 appears to be related to the combination of your medications and supplements, rather than a specific medical condition. As a result, we find that the information in your claim file does not provide satisfactory written proof that as a result of a physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of your Own Occupation throughout the 180 day benefit waiting period ending December 26, 2002 and continuing. Therefore, your claim for LTD benefits is denied.

...

Your claim has been denied for the reasons outlined above. If you want us to review your claim and this decision, you must send us a written request within

180 days after you receive this letter. If you request a review, you will have the right to submit additional information in connection with your claim. Additional information, which would be helpful to a reconsideration of your claim, includes medical records or chart notes indicating that your medical condition is more severe than we previously understood and continues to support your inability to perform the material duties of your own occupation throughout the 180 day benefit waiting period ending December 26, 2002 and continuing. Please include any such new information along with your request for review.

If you request a review, it will be conducted by an individual who was not involved in the original decision. If necessary, the person conducting the review will consult with a medical professional with regard to your claim. This medical professional will be someone who was not previously consulted in connection with your claim. The review would be completed within 45 days after we receive your request unless circumstances beyond our control require an extension of an additional 45 days. If you request a review and the decision to deny your claim is upheld, you will have the right to file suit under Section 502(a) of the Employee Retirement Income Security Act (ERISA) or state law, whichever is applicable.

We want to let you know that upon further investigation, other valid reasons for limiting or denying your claim, which have not been previously considered, could come to our attention. Therefore, Standard Insurance Company reserves the right to

consider and assert other valid reasons for limitation or denial of your claim should they occur in the future.

. . .

Sincerely,
Steven T. Poindexter
Disability Claims Specialist
Employee Benefits Department
. . .

EXCERPTS OF RESPONDENT STANDARD INSURANCE COMPANY'S SECOND ADVERSE BENEFIT DECISION LETTER ("INTERIM DENIAL LETTER"). DATED SEPTEMBER 24, 2003 (9th Circuit ER 221-229)

We are writing in regard to your claim for long term disability (LTD) benefits with Standard Insurance Company and the request for a review of our decision to deny your claim that was submitted by Norman Hessel on your behalf.

First, I would like to address the issue that we have handled your claim with bad faith as charged by Mr. Hessel in his July 21, 2003 letter to Standard Insurance Company. In reviewing your claim for LTD benefits we find that our decision was appropriately based the documentation provided and according to the applicable provisions of the McNees Wallace and Nurick group policy. Contrary to Mr. Hessel's allegations in regard to our evaluation of Dr. Teitelbaum's records, the decision on your claim was not based on one piece of information, but rather careful review and consideration of all the information from all of your medical providers. Although the physician consultant who did review your claim had difficulty reviewing Dr. Teitelbaum' s records as she found them to be partially illegible, the physician consultant did have other medical documentation to review in deriving her opinion including, but not limited to, the Attending Physician Statement and Activities of Daily Living Questionnaire that were completed by Dr. Teitelbaum. Thus the physician consultant was reasonably able to evaluate your medical condition

and functional capacity to perform the duties of your own occupation. Additionally, our written communications to you have been nothing but professional and have provided you a full explanation of our decision on your claim, including all applicable policy provisions. Certainly, there is not support for the assertion of bad faith as charged by Mr. Hessel. Further, our decisions and actions have been consistent with all applicable provisions and guidelines.

...

Along with Mr. Hessel's July 21, 2003 letter, he also provided medical information from Dr. Teitelbaum. In our letter to you dated August 1, 2003, we asked that if you had any additional documentation that you intended to submit, that you notify us in a timely matter so that we could give consideration to that information. As no additional information or notice or intent has been received, we again referred your entire claim file including the recent records from Dr. Teitelbaum to the physician consultant. who as you may recall is board certified In rheumatology, for reevaluation in order to determine your functional capacity.

...

Upon review of these medical records, the physician consultant opines that there is no comprehensive musculoskeletal exam in any of the records. Furthermore, the physician consultant opines that given the diagnosis of fibromyalgia (which Dr. Teitelbaum notes does not meet standard criteria of

greater than 11 or 18 specified tender points), particularly one that is leading to disabling symptoms, one would expect care to be sought from experts in fibromyalgia, who are perceived in the medical community to be rheumatologists. She continues to opine that Dr. Teitelbaum in his records does not demonstrate standard rheumatologic evaluation, differential diagnosis, and treatment; and his articles and writing information that are included with the submitted office visits, do not show any of the usual scientific reasoning nor rationale for the diagnosis of endocrine and rheumatologic disorders.

The physician consultant finds it notable that Dr. Teitelbaum has seen you only twice and has not conducted a comprehensive musculoskeletal exam by rheumatologic criteria. The physician consultant further noted that Dr. Teitelbaum's records from December of 2002 support chronic pain syndrome and myofascial pain syndrome. However, chronic fatigue syndrome is a diagnosis of exclusion and particularly requires the exclusion of depression.

In contrast, the physician consultant cites your visit to Dr. Borror in November of 2002 in which you were noted as doing well. The physician consultant opined that this was a visit of a practitioner who has taken care of you from 1994, and therefore, given the continuity of care his opinion represents that of a consistent medical practitioner with a good knowledge base and perspective of his patient.

Based on a review of the available medical documentation, the physician consultant concluded

the medical records demonstrate support for a diagnosis of depression as of June 28, 2002, precluding you from performing your regular duties of your own occupation as an Attorney on a full time basis. This is based on Dr. Borror's records for treatment of depression and referral to a psychiatrist. However, the physician consultant opined that the records do not support that you remained disabled after your office visit with Dr. Borror in November of 2002. Furthermore, she opined that to satisfactorily demonstrate neuropsychiatric impairment sufficient to impair work inability, one would expect neuropsychiatric evaluations and documentation of that cognitive impairment. These evaluations have not been supplied according to the physician consultant.

The physician consultant found that Dr. Teitelbaum's December 23, 2003 assessment, while noting complaints of pain and finding trigger points, does not contain, among others as stated above, a mental status exam, furthermore, the physician consultant opined that the evaluation by internist, Dr. Rasdogi notes no abnormality on your physical exam, or subjective complaints, except for generalized body aches. The basis for Dr. Rasdogi's assessment of chronic fatigue syndrome, hemochromatosis, and fibromyalgia is not documented, given that she did not perform a musculoskeletal exam, nor is there a documented mental status exam, except that you did not have any neurologic abnormalities. Dr. Rasdogi makes no assessment regarding your mental capabilities.

Lastly. the physician consultant opined that should a diagnosis of fibromyalgia, chronic pain syndrome or Myofascial pain syndrome be well documented, this would not ordinarily interfere with a full time sedentary to light level occupation. She opined that the usual treatment regimen recommendation for patients with fibromyalgia includes light daily aerobics and stretching exercise, low-level antidepressant medications for improving sleep disorder. However, the physician consultant did not see any such recommendations made in your practitioner's records, the physician consultant feels that the medication that you have been prescribed in not considered the accepted treatment for fibromyalgia in the medical community.

After a complete reevaluation of your claim file, including the documentation provided by Mr. Hessel in his letter of July 21, 2003 and the medical file review, we continue to find that as of November 2002 your depression had markedly improved, given your appropriate treatment with antidepressant medications as noted by Dr. Borror. Furthermore, there does not appear to be any subsequent mental status examinations to support the contrary. Although Dr. Teitelbaum has diagnosed you with fibromyalgia, chronic fatigue syndrome and myofa[s]cial pain syndrome, review of the available medical records by a physician board certified in rheumatology, docs not support these diagnoses. Furthermore, the infrequency of your visits with Dr. Teitelbaum is not consistent with severe ongoing limitations and restrictions, nor is his recommended treatment regimen consistent with that recommended by the medical community for such

diagnoses. Moreover, an individual with any of the diagnoses of fibromyalgia. chronic pain disorders or myofascial pain syndrome, is customarily capable of performing sedentary to light level work such as that required of an attorney. As a result, we find that the information in your claim file does not provide satisfactory written proof that as a result of a physical disease, injury, pregnancy, or mental disorder you are unable to perform with reasonable continuity the material duties of your Own Occupation throughout the 180 day benefit waiting period ending December 26, 2002 and continuing. Therefore, you do not meet the Definition of Disability in accordance with the McNees Wallace and Nurick group policy and your claim for LTD benefits most continue to be denied.

As explained in our prior correspondence, you arc entitled to review by an individual who was not involved in the original decision. Thus, we will now refer your claim to our Quality Assurance Unit for further review and analysis of your appeal. It will be conducted by an individual who was not involved in the original decision. They will be in contact with you regarding the status of their review, and they will notify you as soon as they make a determination.

...

Sincerely,
Steven T. Poindexter
Disability Claims Specialist
Employee Benefits Department

. . .

EXCERPTS OF RESPONDENT STANDARD INSURANCE COMPANY'S DENIAL LETTER DATED OCTOBER 23, 2003 (9th Circuit ER 198-208)

Dear Ms. Harris:

The Quality Assurance Unit has completed its review of Standard Insurance Company's decision to deny your long term disability (LTD) claim. This was an independent review, conducted separately from the individuals who made the original claim determination. After carefully considering all of the information in your claim file, we find that the correct decision was to deny your claim.

...

In order to evaluate your claim, The Standard obtained the medical records of Dr. Megan Borror, Dr. John Nipple and Dr. Jacob Teitelbaum. Upon review of all of the available information, The Standard determined that the medical evidence did not provide sufficient proof that you were unable to perform your own occupation from the time you ceased work through the end of the benefit waiting period. This determination was explained in detail in Steven Poindexter's letter of April 25, 2003.

By letter dated July 21. 2003, your husband, Normam Hessel, requested a review of the decision to deny your claim. Along with his letter, Mr. Hessel provided additional information in support of your claim. The additional information was reviewed by the Benefits Department and determined to be insufficient to change the decision to deny your

claim. This determination was explained in detail in Mr. Poindexter's, letter of September 24, 2003.

We understand that there was some misunderstanding regarding the details of the review process. Mr. Hessel has expressed his concern that the initial review of the decision to deny your claim was conducted by the same person who made the initial decision. In addition, the same physician consultant who was consulted during the initial decision to deny your claim was again consulted regarding the additional information provided by Mr. Hessel.

As I explained to Mr. Hessel in our telephone conversation on October 2, 2003, when a review is requested, the first step is for the Benefits Department to review any issues raised and new information provided to determine whether it is sufficient to change the initial determination. If it is determined that it is not, the file is then forwarded to the Quality Assurance Unit for an independent review by someone who was not involved in the initial determination. This independent review will also involve a review of the medical information by a physician consultant who was not consulted during the initial decision process

As noted above you have claimed disability due to fibromyalgia and chronic fatigue syndrome. The diagnosis of fibromyalgia was first suggested by Dr. Teitelbaum on December 23, 2002. There is no mention of fibromyalgia in your medical records prior to that date. There is also no description of reported symptoms or a physical examination

consistent with a diagnosis of fibromyalgia prior to that date.

...

As part of the Quality Assurance Unit's review of the decision to close your claim, the medical information in your file was referred to a physician consultant who was not consulted during the initial decision to deny your claim. This physician consultant concurred with the prior physician consultant's opinion that the records do not support a diagnosis of fibromyalgia. He stated that a specific rheumatologic diagnosis can not be established from the available medical records.

Both physician consultants also stated that, even if the diagnosis of fibromyalgia is correct, this condition would not be expected to prevent you from performing sedentary level work.

...

We find that the dearth of pain complaints in the medical records of your treating physician surrounding the date that you ceased work is not consistent with a pain syndrome, be it chronic pain syndrome, myofa[s]cial pain syndrome or fibromyalgia syndrome, of such severity as to prevent you from performing sedentary level work. Accordingly, we find that the medical evidence does not support that your myofa[s]cial pain syndrome, or "fibromyalgia-like" syndrome, would have precluded your from performing sedentary level work from the

time that you ceased work through the end of the benefit waiting period.

We have also carefully considered the information in your file relating to the diagnosis of CFS.

...

In regard to your cognitive function, both you and Dr. Teitelbaum have suggested that you are unable to perform your own occupation due to impaired cognitive abilities. However, neither of the two physician consultants who reviewed your file could identify any condition that would cause you to suffer from cognitive impairment. In addition, we could find no documentation of significant cognitive impairment in your medical records. There is no mental status examination or neuropsychological testing that documents cognitive deficits. Accordingly, we are unable to approve your claim on the basis of impaired cognitive abilities.

...

Mark Sampson
Benefits Review Specialist

. . .

**EVELYN S. HARRIS,
Plaintiff v. STANDARD
INSURANCE COMPANY,
and McNEES, WALLACE &
NURICK WELFARE
BENEFIT PLAN,
Defendants.**

Nos. 06-1226 PK

**UNITED STATES
DISTRICT COURT
DISTRICT OF OREGON**

**EXCERPTS OF
DECLARATION OF JACOB
TEITELBAUM, M.D.**

Filed October 9, 2007

...

4. I initially evaluated Evelyn Harris on December 23, 2002. At that time she suffered from severe fatigue, widespread pain, and cognitive problems. Her doctor had indicated her problems stemmed from depression, however, she sought my opinion to find out if there was a physical basis for her condition.

5. At that visit I took a history, conducted an Examination, and ordered a number of laboratory tests. As part of my history I learned that severe fatigue and pain were Ms. Harris's primary symptoms. Based on my evaluation, it was my diagnosis that Ms. Harris had chronic fatigue

syndrome and myofascial pain syndrome which was very much like fibromyalgia. She had widespread pain, irritable bowel syndrome, severe fatigue, and cognitive problems. She did not have the 11 of 18 tenderpoints that the 1990 ACR diagnostic criteria establish a basis for diagnosis of fibromyalgia. However the 1996 Consensus Statement recognizes that a patient may still have fibromyalgia in a clinical setting without the requisite 11 tenderpoints if they also [have] symptoms associated with fibromyalgia. Ms. Harris certainly did have a number of associated symptoms including fatigue, cognitive problems, and IBS.

6. The cognitive problems she described were the types of problems commonly found in people with chronic fatigue and fibromyalgia.

7. Ms. Harris told me the cognitive problems were a main reason she had problems functioning in her job as an attorney. These cognitive problems were a big reason she stopped working in June 2002. However, the pain and fatigue she experienced also were problems that affected her ability to show up for work and stay productive at work, independent of any cognitive problems. The post-exertional fatigue and severe pain which she described to me alone would be enough to prevent her from working as an attorney.

Dated this 7th day of October, 2007 at Kona, Hawaii.

/s/ Jacob Teitelbaum
Jacob Teitelbaum, M.D.

**EVELYN S. HARRIS,
Plaintiff v. STANDARD
INSURANCE COMPANY,
and McNEES, WALLACE &
NURICK WELFARE
BENEFIT PLAN,
Defendants.**

Nos. 06-1226 PK

**UNITED STATES
DISTRICT COURT
DISTRICT OF OREGON**

**EXCERPTS OF
DECLARATION OF
PETITIONER
EVELYN HARRIS**

Filed October 9, 2007

...

2. I stopped working with the support of Dr. Borror based on what she believed was my bad mental health condition. However my bad mental health condition resulted from my inability to do my work as an estate attorney because of pain, and fatigue enough to interfere with my ability to work, as well as cognitive problems. Dr. Nipple also told me I should stop working. He could not, however, tell me what was wrong with me - why I had such bad problems with pain and fatigue.

3. Dr. Borror believed that the cognitive problems I noticed were due to medication. However, these

problems have persisted despite stopping the medications.

4. In the November 5, 2002 visit with Dr. Borror, my mental outlook was very improved because I was not working and had not been working for over four months and felt better as my symptoms were under better control. The one day I did return to work in July 2002 to clean up my office, I ended up in bed for two days because of a flare of my symptoms of pain and fatigue. I still had problems with pain and fatigue, but Dr. Borror did not apparently write them down in any detail.

5. Because of continuing problems and the very limited help provided by Dr. Borror, I wanted to seek out other opinions to figure out why I kept suffering from pain and fatigue. After a considerable search, I found Dr. Teitelbaum. In fact, one of my physician clients recommended that I consult Dr. Teitelbaum. When we checked him out we found that he had a national reputation and a good track record in helping people with the types of pain and fatigue symptoms I had.

6. When I met with Dr. Teitelbaum and recounted my history, he explained the physical nature of my conditions and shared his diagnoses. Particularly he said I fit the diagnoses of chronic fatigue syndrome and a fibromyalgia like myofascial pain syndrome. I understood at that time that these diagnoses accounted for the pain and fatigue that was limiting my activity. I had been experiencing these symptoms, the problems that led me to stop work June 28, 2002. In addition to the pain and fatigue I

had cognitive problems, but the pain and fatigue alone kept me from working as an attorney independent of any cognitive problems.

7. While my mental outlook did improve after I stopped working, at no time from June 28, 2002 to the present have I been without pain, fatigue bad enough to interfere with my ability to reliably show up for work or be productive when I could show up. Since the time I left work in June 2002, there has been no time that I have been able to work eight hours a day, five days per week, 50 weeks a year.

...

9. The fatigue I experience is difficult to describe. It is like having the flu with all the energy you have drained from you so all you want to do is stay in bed. Except the flu gets better, while the fatigue that I have is always there at some level. As soon as I increase activity, the fatigue increases to a point that will ultimately make me stop an activity or if I push through, force me to take a day or two off any significant activity.

10. I find this medical condition, Chronic Fatigue Syndrome, FM/Myofascial Pain Syndrome, very frustrating to deal with as on any given day I do not know what I will be able to do. Will I be able to go out or will I need to remain at home to address a flare in symptoms. After many years, I have learned to pace myself to level out the severity of symptoms most of the time. Nevertheless I still have unexpected periods when I must do very little activity to help me get control of my symptoms.

11. Finally, I was very surprised at the results of Dr. Sandman's neuropsychological evaluation. I knew my pain and fatigue alone impaired my ability to function, I was not really aware of the extent of any cognitive problems. I also felt, after completing the testing, that I had done quite well, but the objective data showed that the cognitive problems that interfered with my ability to work as an attorney still remain and cannot now be explained away by complications of medication.

...

12. Despite whatever cognitive problems I have or have had, I am physically unable to work. At the time I stopped working I had considerable trouble dragging myself into work. The fatigue and pain were too much for more than two to three productive hours, I am sure my time records from work would document this. I am also sure my partners could confirm this. It did not occur to us, while we were filing and appealing this claim that this would be the type of information that would be useful to document my disability.

...

14. It was not until we met with counsel that we learned we had a right to the claim file and other materials pursuant to ERISA, that we could have and should have submitted other material, such as neuropsychological testing or physical capacity testing, that there were types of information we could have submitted that Standard should have and did know about, but did not tell us.

Dated this 6th day of October, 2007 at Harrisburg, Pennsylvania

/s/ Evelyn Harris
Evelyn Harris

**EVELYN S. HARRIS,
Plaintiff v. STANDARD
INSURANCE COMPANY,
and McNEES, WALLACE &
NURICK WELFARE
BENEFIT PLAN,
Defendants.**

Nos. 06-1226 PK

**UNITED STATES
DISTRICT COURT
DISTRICT OF OREGON**

**EXCERPTS FROM
DECLARATION OF
NORMAN HESSEL**

Filed October 9, 2007

...

6. I was surprised when Standard Insurance denied [Evelyn's] benefits in April 2003. I know my wife well enough to know that if she was able she would work. She took great pride in her work and success as an estate law attorney.

7. Evelyn's pain and fatigue limiting her activity were very evident to me when I observed my wife at home after a day of work. These are the problems that ultimately forced her to stop working. These same problems persist today despite Evelyn being off work, although they appear to be somewhat more manageable .

8. At the time she stopped working in June 2002, she would come home from work and just crash. She had nothing left after a day of work. In fact for many weeks before she stopped working, she did not go in consistently for full days.

9. I could see her pain in the way she moved. I could see her fatigue as she had no energy left and would often just stay in bed or rest on a couch. In my mind, there was no question that she would not be able to function at the high level expected of an attorney with the problems I observed.

10. I understand that Dr. Borror treated Evelyn for what the doctor thought was a mental health condition - depression, anxiety. However, based on my observations it appeared much more was going on physically. We asked Dr. Borror for referrals to see if we could identify a physical cause for Evelyn's problems. The referrals she gave us were not particularly helpful.

11. Evelyn and I searched for a doctor familiar with the types of symptoms (pain and fatigue) she was experiencing and we found Dr. Teitelbaum. One of Evelyn's physician clients had recommended Dr. Teitelbaum and when we checked him out we believed he would be the perfect doctor to consult regarding Evelyn's condition.

12. After the visit with Dr. Teitelbaum we had a much better understanding of what was going on with Evelyn as he diagnosed chronic fatigue syndrome and a fibromyalgia like myofascial pain syndrome. He paid attention to the history and

recorded all of the problems that Evelyn was having and had been having since before she stopped working in June 2002. These diagnoses explained the basis for the pain and fatigue Evelyn was experiencing.

13. While Evelyn's cognitive problems were a reason she was forced to stop working, the pain and fatigue alone were enough to interfere with her ability to work. The cognitive problems did not force her to stay in bed. The cognitive problems paled in comparison to Evelyn's depleted energy and her pain.

14. Recognizing that she was likely to have long term problems with pain and fatigue, after the visit with Dr, Teitelbaum, Evelyn applied for long term disability benefits with my support and Dr. Teitelbaum's support. I actually prepared the forms for her as she was unable to do it herself.

15. After our application was in, we cooperated in every possible way with Steven Poindexter while he evaluated Evelyn's claim. He told us he was gathering necessary information from Evelyn's doctors. We had several letters in that regard. He never asked us for any further information, and led us to believe he was doing all that would be necessary to fairly evaluate Evelyn's claim and grant her benefits. The only time he asked us for anything is when he sought Dr. Borror's records.

16. In April 2002, I called and talked to Mr. Poindexter to find out the status of the claim. I wanted to know if he had received all the records. He

told me had received all the records. He also told me that Standard had decided to deny Evelyn's claim.

...

17. When I received the [denial] letter and read it, it was my opinion that Mr. Poindexter had unfairly evaluated Evelyn's claim. The letter criticized Dr. Teitelbaum, and rested heavily on Dr. Borror's evaluation, particularly a November 5, 2002 note in which Dr. Borror wrote that Evelyn feels 100% better with respect to her depression. The letter expresses criticism of Dr. Teitelbaum but admits they were not able to read his notes. Relying on the one note indicating Evelyn's mental health condition had improved on one day, did not in any way address the ongoing problems with pain and fatigue for which we continued to seek medical advice.

...

19. I prepared the appeal as the letter suggested. We provided records from Dr. Patel and Dr. Rastogi who supported Dr. Teitelbaum's diagnoses. I had Dr. Teitelbaum transcribe his "illegible records" so we would all have the benefit of those records. I provided articles and a letter describing Dr. Teitelbaum's treatment approach. I provided the Northwestern Mutual Life decision to waive premiums based on disability. I also had Dr. Teitelbaum write a letter describing the basis for his opinions that he had submitted on his Attending Physician Statement. Again, we believed that the pain and fatigue that Evelyn suffered should have been sufficient to justify award of benefits under her policy.

20. Nothing in this letter from Mr. Poindexter fully informed me about be type of information I needed to submit to perfect Evelyn's claim on appeal other than to submit medical records.

...

21. In fact, Social Security granted the benefits first time through based on a date of disability of July 1, 2002, and they have been paying benefits ever since that time. The information we submitted to Social Security documented the pain and fatigue due to Chronic Fatigue Syndrome and myofascial pain/fibromyalgia.

22. The appeal I submitted to Standard, nevertheless, was still denied by Mark Sampson in Standard's Quality Review Unit.

...

25. When counsel got the materials from Standard we were entitled to under ERISA, we had a chance for the first time to see the record reviews done by Dr. Ingram and Dr. Fancher. In particular, we noted that Dr. Ingram had recommended obtaining psychiatric or neurocognitive testing records if present...If we had been told that one type of information that would have been useful would be neuropsychological testing, we would have obtained that testing.

...

27. Based on a recommendation from our attorney, we have now obtained that cognitive testing.

...

28. The reason the results on neuropsychological testing surprised us is the fact that the main problems we deal with all the time are Evelyn's forced inactivity due to her pain and fatigue, as well as problems with irritable bowel syndrome. We have been less aware of the ongoing cognitive problems. Based all my observation, the pain and fatigue force Evelyn to curtail activity, and at times stay in bed or on a couch and are the reason she is unable to work as an attorney, or for that matter, in any other occupation. The symptoms wax and wane. The pain and fatigue get worse with any significant activity causing Evelyn to just shut down, if not crash. We make decisions all the time whether or not to do an activity based on how Evelyn is feeling. We build in planned down time so she can recover from the activity. Since she stopped working she has never done a full week of any physical activity, nor would I expect she would be able to if she was foolish enough to try. The pain and fatigue, flared by activity make it difficult to plan activities and there have been times when plans had to be set aside because her symptoms had flared and she needed to stay close to home or in bed.

29. This pain and fatigue that I describe now, is the same pain and fatigue that forced Evelyn to stop working in June 2002. Except now, with pacing, Evelyn can manage it better.

Dated this 7th day of October, 2007 at Harrisburg, Pennsylvania.

/s/ Norman Hessel
Norman Hessel

EXCERPTS FROM DEPOSITION OF RESPONDENT STANDARD INSURANCE COMPANY'S DISABILITY CLAIMS SPECIALIST STEVEN POINDEXTER (TAKEN JULY 20, 2007 BY PETITIONER'S COUNSEL, STEVEN P. KRAFCHICK) – Pgs. 44-47 (ER 192)

Q. Do you see it as your obligation to let a claimant know the type of information he or she needs to provide to perfect a claim?

A. It is my obligation?

Q. Do you see it as your obligation?

A. Yes.

Q. So, for instance, if a claimant is claiming a cognitive disability, would you then say it would be advisable for them to get neuropsych testing to prove it?

A. We would – no.

Q. Why not?

A. Within the contractual provisions of the policy, proof of loss, the burden of responsibility is put on the claimant to provide us with information that they feel is relevant to make an appropriate decision on their claim.

We are not to advise any sort of medical opinions, as far as what they need to obtain or what they shouldn't obtain with regards to that. Whatever information they would like for us to provide or they would like to provide us or would like for us to obtain, and that's what we will make a decision on.

Q. Do you see it as your obligation to let a claimant know the type of information he or she needs to provide to perfect a claim?

A. It is my obligation?

Q Do you see it as your obligation?

A. Yes.

Q. So, for instance, if a claimant is claiming a cognitive disability, would you then say it would be advisable for them to get neuropsych testing to prove it?

A. We would -- no.

Q. Why not?

A. Within the contractual provisions of the policy, proof of loss, the burden of responsibility is put on the claimant to provide us with information that they feel is relevant to make an appropriate decision on their claim. We are not to advise any sort of medical opinions, as far as what they need to obtain or what they shouldn't obtain with

regards to that. Whatever information they would like for us to provide or they would like to provide us or would like for us to obtain, and that's what we will make a decision on.

Q. Do you understand -- well, what type of training do you have regarding your responsibilities under ERISA?

A. I would have gone through the training in my new analyst training to address ERISA, as well as any other department updated trainings that would have occurred.

Q. What is your understanding of your obligations under ERISA to the claimant?

A. My understanding is it is with regards to the review procedures and the timeliness in which that review needs to be conducted.

Q. Have you been advised on the type of notice you need to provide to claimants if the decision is to deny a claim?

A. Yes.

Q. What have you been advised?

A. To provide them a full and thorough summary of the information that we had used in rendering our opinion.

Q. Anything else?

A. Any supporting documents that they would wish to obtain, we would provide that as well, too.

Q. You mean from the claim file?

A. Correct.

Q. Are you -- under ERISA, is it your understanding that you are obligated to tell them what type of information they should submit in order to perfect their claim?

A. No.

Q. You are not? It is your understanding that you are not supposed to?

A. To tell them what information they need to provide me?

Q. Correct.

A. No.

EXCERPTS FROM DEPOSITION OF RESPONDENT STANDARD INSURANCE COMPANY'S BENEFITS REVIEW SPECIALIST MARK SAMPSON (TAKEN JULY 20, 2007 BY PETITIONER'S COUNSEL, STEVEN P. KRAFCHICK) – Pgs. 16-21 (ER 197)

Q. When you are reviewing the medical records at your level, in Ms. Harris' case, did you view the claim file as one which would have benefitted from a neuropsychological evaluation?

A. Had there been a neuropsych evaluation, yes, it would have been helpful had it been in the records. I don't think it would have been helpful at the time that it reached the Quality Assurance Unit.

Q. So as a person looking at it from the standpoint of quality assurance, you identified that that was lacking in the record?

A. Yes.

Q. At that point you believed there was nothing you could do about that?

A. Yes.

Q. Okay. In quality assurance, do you have the ability to send a claim back for further evaluations of claimant?

A. Yes.

Q. And that was not an option you looked at in this case?

A. I don't recall whether I considered that or not, but it –

Q. Didn't do it?

A. Right

Q. So once the claim came to you, what was your process?

What are you looking at?

A. I just start with the claim file and go through it page by page.

Q. And when you do that, what are you looking for?

A. To determine whether or not the decision was accurate.

Q. Are you evaluating at that time whether the claim was handled appropriately at the benefits level?

A. Yes.

Q. So would you be -- well, let me back up. Do you evaluate the denial letters to determine if they were adequate under ERISA?

A. No.

Q. Have you had any training on ERISA?

A. Yes.

Q. What do you see as your obligations as a benefit analyst or a senior benefit analyst under ERISA, obligations to the claimant?

MS. SOMERVELL: I object, because he is not a benefit analyst. He is a --

MR. KRAFCHICK: Specialist.

MS. SOMERVELL: He is a review specialist.

MR. KRAFCHICK: Pardon me.

BY MR. KRAFCHICK:

Q. You are a senior review specialist now?

A. Benefits review specialist.

Q. Benefits review specialist. And the job you held at the time you were working on Ms. Harris' claim, what did you see your obligations to the claimant under ERISA?

A. There is obligations on terms of timeliness, and in terms of evaluating, obviously, on a fair and objective manner, and evaluating all of the medical evidence, and also, in this case, to obtain a second medical opinion.

Q. Why was it necessary to obtain a second medical opinion of this case?

A. The Department of Labor regulations require if the claim is based on a medical judgment that a second medical opinion be obtained.

Q. Have you had training on ERISA?

A. Yes.

Q. Can you give me a sense of how much training you have had on ERISA?

A. Probably been at least two, one and two-hour trainings.

Q. How recently?

A. Probably within the last year. Actually, there was a follow-up training probably six months ago.

Q. Okay. Had you had any ERISA training at the time of Ms. Harris' claim?

A. Yes.

Q. What kind of training had you had as of that time?

A. There would have been at least one. There would have been the two, one to two-hour training on the Department of Labor regulations.

Q. And based on those trainings, what do you see as the obligations you would have to the claimant in evaluating the claim?

A. At my level?

Q. At your level.

A. Essentially as I described before.

Q. So in her case, timeliness; in other words, meeting the deadlines that ERISA requires, do a review of the evidence, and be fair and objective about that, and then obtain a second medical opinion, because the denial was based on medical judgment. Is that --

A. Yes.

Q. Is there anything else?

A. Not that I can think of.

Q. Did you see that as part of your role in evaluating a prior decision in employee

benefits to look to see if the claimant had been properly advised as to information she could submit to perfect her claim?

A. To evaluate the -- the decision letter?

Q. Correct.

A. No, I don't think so.

Q. So if I am understanding it, you take the claim file from below, you look at the decision that was rendered below, you comply with ERISA timelines in your decision making --

A. Uh-huh.

Q. -- you try and take as fair a look at the evidence as you can. In this case, you obtain a second medical opinion?

A. Uh-huh.

EXCERPTS FROM CURT SANDMAN, Ph.D.,
(PETITIONER'S EXPERT),
NEUROPSYCHOLOGIAL EVALUATION DATED
9/5/07 (9th Circuit ER 140)

...

From findings of the current evaluation it is concluded that Ms. Harris has impairments in memory, attention and concentration that are more significant and profound than would be expected from the assessment of general intelligence. There is concern that her impaired abilities as measured in this evaluation reflect both the effects of pain and discomfort related to fibromyalgia and chronic fatigue. Her impaired performance on tests of memory and her inconsistent pattern of response was not related to malingering tendencies. She performed in the highly motivated range on the performance-based test of symptom-validation. Moreover, there was evidence on the MMPI that she responds in an open and cooperative manner. It is highly probable that the pattern of scores reflect a loss of skills related to her condition of chronic pain and fatigue. It would be a mistake to label her memory ability to be normal because her scores are in the average range. Her normal level of intellectual function is in the superior range, based on premorbid estimates, measures of intellectual abilities from the WAIS-III and past accomplishments. Her relative deficits in memory are widespread and significant and they impair her ability to recall facts and figures and to respond quickly (normally) and efficiently.

Her deficits in executive function suggest that neurological complications should be ruled out.

From the tests of cognitive function administered and the information collected by self-report in the interview, it is my opinion that Ms. Harris is significantly and permanently disabled to perform the activities of her profession. Moreover, it is unlikely that she can reliably perform duties requiring attention, concentration, efficient and expedient decision making and recall of facts. Therefore, based on the results of my evaluation including my testing and the history I have obtained from Ms. Harris, it is my opinion that she cannot perform the material duties of her profession, nor can she perform the material duties of any occupation. Based on the history I obtained, it is also my opinion that these deficits that were evident during my testing and prevent performing material duties of her own or any occupation, are due to her fibromyalgia and chronic fatigue and likely have been present since 2001.

Respectfully Submitted,

/s/ Curt A. Sandman
Curt A. Sandman, Ph.D.
Professor and Vice Chair
Department of Psychiatry
University of California, Irvine
Licensed Clinical Psychologist
License Number PE 6893

EXCERPTS FROM SHIRLEY INGRAM, M.D., STANDARD'S PHYSICIAN CONSULTANT/RECORD REVIEWER, DATED 4/8/03 (9th Circuit ER 373-375)

...

On 9/26/2002 follow-up for depression noted that the Effexor had made her tired and Zoloft was begun. It was also noted that she was offwork in July and August and decided that she couldn't go back and when she went back in to clear up her office she ended up staring in bad for two days. On exam, she still had a mildly depressed affect. Weight was increased by 2 pounds to 109 and the assessment was that she was improved but still some fatigue and sleep disturbance and Zoloft was increased. Office visit 11/5/02 states that she is 100% better regarding depression and that the increase in Zoloft had helped and had not problem with appetite, stomach, and was enjoying life. ...

...

I recommend obtaining any psychiatric or neurocognitive testing records if present. ...

EXCERPTS FROM EVELYN HARRIS'S LONG TERM DISABILITY APPLICATION DATED 1/25/03 (9th Circuit ER 424-426)

2. EMPLOYMENT

...

Last full day of work: 6/28/02

...

3. SICKNESS: Please list all illnesses which contribute to your being unable to work at your occupation

Illness: Chronic Fatigue Autoimmune Dysfunction Syndrome/Fibromyalgia

Date first noticed: 10/2001

State what you believe caused your illness: Cause Unknown

Describe your symptoms *preventing you from working*: Fatigue and cronic [sic] pain, reduced ability to concentrate

EXCERTS FROM JACOB TEITELBAUM, M.D.'S ATTENDING PHYSICIAN STATEMENT DATED 12/23/02 (9th Circuit ER 427-428)

Primary Diagnosis: Myofascial Pain Syndrome
Secondary Diagnosis: Chronic Fatigue Syndrome

...

Symptoms: Severe insomnia, widespread severe pain, _____ cognitive dysfunction, severe fatigue and exhaustion with stress or attempts at sustained activities.

...

Date you recommend patient should stop working: 12/23/02

Why: History suggests that 1) her disability prevents her effectively working 2) the stress of working can dramatically worsen her disability.

Describe the patient's physical, mental and cognitive limitations and work activity limitations: Pain and exhaustion prevent sustained activity, cognitive dysfunction prevents her properly functioning as an attorney

EXCERPTS FROM DR. BORROR'S MEDICAL RECORDS

11/5/02: Here to review adjustment disorder, depressed mood. She says she is 100% better, feels better than she has felt in years. She enjoys being off, taking care of home, re-acquainting her self w/ sisters and mother and spending time w/ them. Increase in Zoloft seems to have helped a lot. (9th Circuit ER 386)

9/26/02: Pt presents for review of depression. When last seen we had tapered her off Effexor because it was making her very tired. She had decreased energy and was not doing very well on it in terms of improvement of her sx. ... She was off work in July and August to see if taking time off would help her as she pulled things together then at the end of that time period decided that she couldn't go back to work. She felt significantly better off work and then went in one day to clear things out and ended up spending the next 2 days in bed. (9th Circuit ER 388)

6/17/02: Here to review depression. She is not doing any better, ... Fatigue is still problem but not as bad as it has been. Still has decreased energy, loss of ambition and has noticed since on Effexor she is making some mistakes w/ dictating letters and using words she did not plan to use. ... (9th Circuit ER 389)

(3)

No. 08-1585

Supreme Court, U.S.
FILED
AUG 26 2009
OFFICE OF THE CLERK

In The

Supreme Court of the United States

EVELYN S. HARRIS,

Petitioner,

v.

THE STANDARD INSURANCE COMPANY and MCNEES, WALLACE, & NURICK WELFARE BENEFIT PLAN,

Respondents.

On Petition For Writ Of *Certiorari* To The United States Court Of Appeals For The Ninth Circuit

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QUESTIONS PRESENTED

1. Has Petitioner established an existing conflict among the Circuits regarding the need to disclose information developed during the administrative appeal process for claims under the Employee Retirement Income Security Act of 1974[1] ("ERISA") involving disability benefits and a Plan Administrator with a structural conflict-of-interest?

2. Has Petitioner established a relevant conflict among the Circuits regarding the ability of District Courts to consider evidence beyond the administrative record based on allegations that (a) the Plan Administrator failed to satisfy the minimum regulatory requirements for handling ERISA claims, and (b) the alleged errors affected the record subject to administrative review, such that there is a need for further guidance from this Court on how to apply its decision in *Metropolitan Life Ins. Co. v. Glenn*, ___ U.S. ___, 128 S.Ct. 2343 (2008), or the Department of Labor's regulations governing disability claims?

3. Has Petitioner established a basis for this Court to exercise its supervisory powers to step in and define what constitutes (a) the "full and fair review" provided for by the regulations governing ERISA claims, or (b) the "higher than marketplace" duty discussed in *Metropolitan Life Ins. Co. v. Glenn*, *supra*?

---

[1] 29 U.S.C. §1001, *et seq*.

CORPORATE DISCLOSURE STATEMENT

Respondent Standard Insurance Company is a wholly-owned subsidiary of Stancorp Financial Group, Portland, Oregon, which is publicly traded on the New York Stock Exchange.

Respondent McNees, Wallace & Nurick Welfare Benefit Plan is an ERISA plan and is not a corporation.

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INTRODUCTION

Petitioner Evelyn S. Harris ("Petitioner") asks this Court to grant *certiorari* and review the decision of the United States Court of Appeals for the Ninth Circuit,[2] which affirmed the decision of the United States District Court for the District of Oregon[3] adopting the Findings and Recommendations of a Magistrate Judge.[4] The Magistrate and District Court had upheld the decision by Respondent The Standard Insurance Company ("Standard") denying Petitioner's claim for long-term disability benefits under Respondent McNees, Wallace & Nurick Welfare Benefit Plan ("the Plan"). Petitioner contends that review is necessary to resolve two alleged conflicts among the Circuit Courts and to "define and apply" (a) ERISA's mandate to provide "full and fair review" for handling disability claims, and (b) what constitutes the "higher than marketplace" duty imposed on "dual-role" Plan Administrators under this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, *supra*. This Court should deny the Petition because the first claimed conflict does not exist, the second claimed conflict, if it does exist, is not relevant to this case, and, in any event, the concern Petitioner raises is answered by this Court's decision in *Glenn*.

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[2] App. 1a.

[3] App. 5a.

[4] App. 7a.

STATEMENT OF THE CASE

A. Petitioner's Disability Claim and the Plan Administrator's Determination

Petitioner was employed by the law firm McNees, Wallace & Nurick as an estate planning attorney from April 2001 until June 2002, when Petitioner quit her job and negotiated her withdrawal from the firm. App. 9a-10a, 13a. One of the benefits provided by the firm was the Plan, which included long-term disability benefits pursuant to a group Long-Term Disability Policy issued by Standard. The Plan provided that to be eligible for long-term disability benefits, a claimant must remain continuously disabled under the terms of the Plan throughout the benefit-waiting-period (*i.e.*, for 180-days following the onset of a disability). App. 9a-10a. The Plan defined "disability" as:

> During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.
>
> You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:
>
> 1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and
>
> 2. You suffer a loss of at least 20% in your indexed Predisability Earnings when working in your Own Occupation.

App. 10a.

In January 2003, following the 180-day waiting period, Petitioner filed a claim for long-term disability benefits under the Plan, claiming that she became disabled from performing her own occupation as an attorney based on two conditions – chronic fatigue syndrome ("CFS") and fibromyalgia – which Petitioner stated began in October 2001. Petitioner identified her attending physicians as Dr. Jacob Teitelbaum, Dr. Megan Borror, and Dr. John Nipple. App. 14a-15a; A.R. 197-99.[5]

Medical records from Petitioner's general practice physician – Dr. Borror – reflected that in October 2001, Petitioner complained of symptoms of moodiness, irritability, and fatigue. Dr. Borror noted that Petitioner had been going through perimenopause and had "gone through a lot" during the prior year, including changing jobs, her father's death, and her only son leaving for college. Dr. Borror concluded that Petitioner's symptoms likely were related to a combination of changes in hormone levels and the recent stress in her life, and that Petitioner's condition probably would be a "short term thing." Dr. Borror prescribed hormone replacement therapy to treat Petitioner's symptoms. App. 11a; A.R. 327-28.

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[5] "A.R." refers to the Administrative Record filed in this action. The Magistrate cited to the A.R. in his Findings and Recommendations, and the A.R. contains the facts not discussed in detail in the Magistrate's Findings.

In December 2001, Petitioner reported to Dr. Borror that Petitioner's prior problems – inability to sleep through the night, moodiness, and irritability – plus her depression all were under control. When Petitioner saw Dr. Borror later that month, Petitioner reported that things had improved significantly, she was able to concentrate on work, and she no longer had significant mood swings or irritability. Petitioner said she was getting through her work day just fine and no longer got physically sick when she looked at her workload. Dr. Borror noted that Petitioner's affect was full and normal, and she did not seem anxious. App. 11a-12a; A.R. 329.

Dr. Borror's records showed that Petitioner's condition began to worsen again in May 2002, when Petitioner reported that she was experiencing problems with "decreased energy, sense of being tired, not having energy to get out of chair. Low ambition, no drive." App. 12a. Petitioner reported feeling "physically achy" after she had worked in her garden. She told Dr. Borror that she believed some of her symptoms were related to depression, noting that she was dealing with issues at work and was upset by her college-age son "testing her limits." Petitioner also reported that she had reached the point where she needed to make a decision about "where she was going" with her job and whether she wanted to continue working full-time or cut back. Dr. Borror advised Petitioner to reduce her alcohol consumption and change the time of day she took the Effexor

Dr. Borror had prescribed for Petitioner's depression. App. 12a; A.R. 330-31.

In June 2002, just two weeks before quitting her job, Petitioner reported that she still suffered from decreased energy and a loss of ambition, noting that since she started taking Effexor, she had problems she had not had before, such as making mistakes when dictating letters and speaking, using words she had not planned to use, and having days when she could not face going to work. Dr. Borror advised Petitioner to taper off the Effexor. App. 12a-13a.

Dr. Borror referred Petitioner to Dr. John Nipple to evaluate whether there were any physical causes for her symptoms. Dr. Nipple performed several tests, all of which were normal with the exception of a low vitamin B-12 level. Dr. Borror recommended monthly vitamin B-12 injections. App. 13a.

When Petitioner returned to Dr. Borror in September 2002, Petitioner reported that since she had stopped working, she felt significantly better. Petitioner believed her problems were directly related to her job and the practice of law, and Petitioner did not know whether she would ever return to practicing law. App. 13a. In November 2002, Petitioner told Dr. Borror that Petitioner was "100% better, feels better than she has felt in years." App. 14a. Petitioner said she enjoyed being off work, taking care of her home, and spending time with her sisters and mother. Petitioner had no problems with her appetite or stomach, and was enjoying life. Dr. Borror concluded

that Petitioner's adjustment disorder and depressed mood were "much better since leaving job, I think she made big turnaround." App. 14a.

In December 2002, Petitioner asked Dr. Borror to fax Petitioner's medical records to Dr. Jacob Teitelbaum, a specialist in CFS. Petitioner then saw Dr. Teitelbaum for the first time. His report differs markedly with Dr. Borror's report from just one month earlier. Dr. Teitelbaum diagnosed Petitioner with myofascial pain syndrome, with a secondary diagnosis of CFS. His notes indicate that Petitioner had severe fatigue, pain and cognitive dysfunction associated with myofascial pain syndrome and CFS, together with severe sleep disorder. Dr. Teitelbaum opined that Petitioner was unable to perform her job as an attorney because of those symptoms, and attempting to work would likely cause Petitioner's symptoms to flare and risk leaving her bed-ridden with CFS and unable to do activities of daily living. Dr. Teitelbaum concluded that Petitioner was "100% disabled from her current occupation." App. 14a; A.R. 196, 459.

In January 2003, six months after she left work, Petitioner applied for long-term disability benefits, describing her illness as CFS with Immune Dysfunction Syndrome/Fibromyalgia, and her symptoms as fatigue, chronic pain, and reduced ability to concentrate. App. 14a-15a. Standard referred Petitioner's file to consulting rheumatologist Dr. Shirley Ingram for review. In April 2003, Dr. Ingram issued a report questioning Dr. Teitelbaum's diagnoses, noting that

CFS is a diagnosis of exclusion and that the medical community agrees that CFS is not a tenable diagnosis in the presence of depression, which has identical symptoms. Dr. Ingram noted the absence of pain symptoms in Petitioner's medical records and that Dr. Teitelbaum never diagnosed Petitioner with fibromyalgia. Dr. Ingram also was concerned that, on Dr. Teitelbaum's recommendation, Petitioner was taking 24 different medications and supplements, which created a great risk of drug interaction and oversedation. Finally, Dr. Ingram questioned Dr. Teitelbaum's plan not to see Petitioner again for five months if his diagnosis was accurate. Based on her review of Petitioner's records, Dr. Ingram concluded that the medical evidence supported a diagnosis of depression, for which Petitioner had received appropriate treatment from Dr. Borror, and that Petitioner's condition had sufficiently improved by November 2002 to allow her return to work. Dr. Ingram recommended that Standard obtain records of any psychiatric or neurocognitive tests, ***if any had been done***. App. 15a-16a.

Standard sent Petitioner a letter dated April 25, 2003, denying her claim for long-term disability benefits on the ground that she had not shown she was totally disabled throughout the 180-day benefit-waiting-period ending December 26, 2002. Standard explained its decision in detail, discussing the relevant plan requirements, identifying the medical information on which Standard relied, the basis for

its conclusions, and Petitioner's right to appeal Standard's decision. App. 16a, 45a-49a; A.R. 355-62.[6]

Petitioner appealed Standard's denial by letter dated July 21, 2003, enclosing additional documentation. App. 16a; A.R. 461-63. Petitioner provided her patient files from Drs. Patel and. Rastogi,[7] as well as articles on the effective treatment of fibromyalgia and myofascial pain syndrome. Petitioner also included a letter from Dr. Teitelbaum stating his continued belief that Petitioner was completely disabled from virtually all activity. App. 16a-17a.

Because Petitioner's appeal appeared to suggest bad faith or some procedural irregularity on Standard's part, Standard sent Petitioner's file and her July 2003 letter back to the original claims specialist and consulting physician for further review.[8] Dr.

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[6] Petitioner included limited portions of that letter in her Appendix.

[7] Dr. Patel diagnosed Petitioner with mild macrocytic anemia, which he opined was likely due to her alcohol intake. Dr. Patel advised Petitioner to cease all alcohol consumption for two weeks. He also expressed surprise that Dr. Teitelbaum had Petitioner taking 24-27 different medications. App. 16a-17a.

Dr. Rastogi, an internist, saw Petitioner only once. Although Dr. Rastogi appeared to have diagnosed Petitioner with CFS, hemochromatosis, and fibromyalgia, her testing did not reveal any data to support such diagnoses. App. 17a.

[8] Contrary to Petitioner's statement (Pet. 23), that was ***not*** the administrative review contemplated by 29 C.F.R. §2560.503-1(h)(3)(ii) and (iv). Instead, it was an extra step Standard undertook voluntarily to ensure no errors had been made in the initial evaluation. Although Standard was not required to do so, it

(Continued on following page)

Ingram concluded that the additional information did not support the existence of any condition that would have precluded Petitioner from returning to work in November 2002. App. 17a.

After concluding that the new information did not change the initial evaluation done in April, Standard forwarded Petitioner's entire claim file to the "Quality Assurance Unit" for an independent review. App. 17a. Standard also sent Petitioner a letter, dated September 24, 2002, advising Petitioner that the file had been forwarded to the Quality Assurance Unit, following review by the original claims specialist. Standard repeated that Petitioner's medical records did not support a diagnosis of CFS or fibromyalgia, adding that Dr. Teitelbaum's methodology did not comport with standard rheumatologic evaluation and was not supported by standard scientific reasoning, and his treatment was not generally accepted within the medical community. Finally, Standard noted the absence in Petitioner's records of any neuropsychiatric evaluations or other documentation of cognitive impairment. App. 17a-18a, 50a-55a.

The Quality Assurance review was handled by a new claims specialist, who consulted with Dr. Bradley Fancher, Board Certified in Internal Medicine. In an

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notified Petitioner that Standard had undertaken this additional step before sending the file on for the independent review called for by the regulations. App. 17a-18a.

October 2003 report, Dr. Fancher noted that prior to meeting Dr. Teitelbaum in December 2002, Petitioner's history was primarily one of moodiness, irritability, and depression. Dr. Fancher questioned Dr. Teitelbaum's diagnosis of CFS due to insufficient evidence, especially where there was no indication that Dr. Teitelbaum had reviewed Petitioner's medical records, taken a mental health history, or conducted a mental health examination or cognitive testing. Dr. Fancher found the diagnosis of fibromyalgia similarly curious where Dr. Teitelbaum admitted that Petitioner did not have 11 of the 18 "trigger points" commonly required to support such a diagnosis. Dr. Fancher noted that all of Petitioner's lab results were normal, other than an elevated MCV which Dr. Rastogi attributed to Petitioner's alcohol consumption. Dr. Fancher concluded that the medical records supported a diagnosis of adjustment disorder associated with depression, but did not demonstrate a physical or mental condition that would have kept Petitioner from working throughout the entire benefit-waiting-period. App. 18a-19a.

Standard sent Petitioner a letter dated October 23, 2003 making final the decision denying her claim for long-term disability benefits. App. 19a. Standard set out the reasons for its conclusion that Petitioner did not have fibromyalgia, adding that such a condition and other pain syndromes do not disable a person from performing the sedentary to light-level work done by attorneys. Standard explained that Petitioner's diagnosis of depression or adjustment

disorder would account for her symptoms of fatigue and precluded a diagnosis of CFS. Standard concluded that Dr. Borror's November 5, 2002 chart note documenting Petitioner's own report of her significantly improved condition demonstrated that Petitioner had not been ***continuously disabled*** throughout the benefit-waiting-period. Finally, Standard advised Petitioner of her right to obtain documents in her file free of charge, and to seek judicial review. App. 19a, 56a-59a.

B. Petitioner's ERISA Action and the District Court's Rulings

Petitioner filed this action, alleging that Standard had violated ERISA and breached its fiduciary duty by improperly denying Petitioner's claim for long-term disability benefits. App. 7a-8a. Respondents denied Petitioner's claims and alleged, *inter alia*, that Petitioner's entitlement to benefits was limited by the terms of Standard's Long-Term Disability Policy, and that Standard complied with, and performed, all of its promises, obligations, and duties under ERISA and the terms of the Plan.

Both sides moved for summary judgment. App. 8a. Respondents contended that the Plan conferred discretion on Standard to administer the Plan and make final benefits determinations, and that Standard had not abused its discretion in denying Petitioner's claim because the decision was both reasonable and supported by substantial evidence in

the administrative record. Petitioner contended that Standard had committed "flagrant violations" of ERISA regulations by depriving her of an understanding of what she needed to submit to "perfect her claim."

Petitioner also submitted additional evidence that she had not submitted during the administrative proceeding. Petitioner urged the District Court to (a) consider the additional evidence, and (b) allow Petitioner to obtain through discovery still more evidence that she claimed she needed to cure Standard's alleged failure to comply with its fiduciary obligations and applicable ERISA regulations. App. 33a-34a.

Respondents moved to strike Petitioner's "extra-record" evidence, noting that she was not entitled to rely on evidence outside the Administrative Record. Respondents argued that Standard provided Petitioner all the information she was entitled to at all appropriate times. App. 34a. Petitioner opposed the motion to strike, arguing that Standard had an obligation to provide, in language Petitioner could understand, notice regarding the kind of evidence needed to perfect her claim and that because Standard failed to do so, Petitioner was entitled to present evidence outside the Administrative Record to cure any defects resulting from the alleged procedural violations.

A Magistrate Judge entered Findings and Recommendations in favor of Respondents, stating, *inter alia*:

> [T]his Court concludes Standard committed no procedural errors in processing [Petitioner's] claim, and thus that its decision to deny [Petitioner's] benefits may be reviewed for abuse of discretion only. The Court further concludes that, in light of Standard's structural conflict of interest, its benefits decision must be reviewed with a cognizable but low level of skepticism.
>
> ....
>
> The existence of evidence in the record that would have supported a contrary conclusion is not evidence of abuse of discretion.... Because there was a factual basis in the record to support Standard's decision, and because Standard's decision was reasonable in light of that factual basis, this court must conclude that Standard did not abuse its discretion in denying benefits to [Petitioner].

App. 21a, 38a. Petitioner objected to the Findings and Recommendations, arguing that the Magistrate's Order rested on a finding that Standard had not violated ERISA's minimum requirements, which was contrary to the facts and the applicable statutes, regulations, and case law. Respondents opposed Petitioner's objections, pointing out that her challenges rested on the erroneous assumption that Standard had denied her claim for the sole reason that she had

failed to submit evidence of neurocognitive deficits, but that Standard's decision actually was based on affirmative evidence that her condition had improved to the point where she did not remain totally disabled during the entire benefit-waiting-period.

After reviewing Petitioner's objections, the Magistrate's Findings and Recommendations, and the summary judgment record, the District Court Judge agreed with the Magistrate:

> This Court has carefully considered [Petitioner's] Objections and concludes that they do not provide a basis to modify the Findings and Recommendations. The Court also has reviewed the pertinent portions of the record *de novo* and does not find any error in the Magistrate Judge's Findings and Recommendations.

App. 6a. The District Court adopted the Magistrate's Findings and Recommendations, granted Respondents' motion for summary judgment, and entered a Judgment dismissing Petitioner's claims.

C. The Ninth Circuit's Decision

Petitioner appealed to the Ninth Circuit, contending that the District Court erred in upholding Standard's determination because (1) Standard failed to provide the "full and fair review" required by ERISA; (2) the Court failed to treat Standard's second denial letter as an "adverse benefit determination on review" subject to certain ERISA regulations; (3) the

Court failed to impose *de novo* review due to Standard's "flagrant violations" of ERISA regulations; and (4) the Court failed to consider the Petitioner's additional evidence offered to address gaps created by Standard's violations of the minimum procedural requirements. Standard contended that there was no basis to impose a standard of review other than abuse of discretion or to admit evidence not included in the administrative record. Standard also argued that the District Court properly ruled that Standard had not abused its discretion in denying Petitioner's claim where Standard reasonably relied on the opinions from its physician consultants, Standard's determination was both reasonable and well supported by the administrative record, and the diagnosis by Petitioner's physician (who came very late to the table) was questionable and not dispositive of disability.

The Ninth Circuit rejected the argument that Standard committed "flagrant violations" of ERISA regulations and also rejected the contention that Petitioner was entitled to *de novo* review. Instead, the Plan Administrator's structural conflict was one of the factors to be considered in evaluating the claim. App. 2a, *citing Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006).

The Ninth Circuit did find one error in the District Court's decision – the Ninth Circuit concluded that Standard had erred in including in its

"interim" denial letter[9] an additional reason for denying Petitioner's claim. The Ninth Circuit concluded, therefore, that the District Court should have considered Petitioner's additional evidence. App. 3a. The Ninth Circuit went on to consider that evidence. After doing so, however, the Ninth Circuit affirmed the lower court's decision upholding Standard's determination that Petitioner had not presented evidence that she had been disabled throughout the entire benefit-waiting-period. App. 3a-4a.

REASONS FOR DENYING THE WRIT

A. Petitioner failed to establish a Circuit split or any other issue justifying Supreme Court review.

1. The standard of review for determinations by Plan Administrators with structural conflicts-of-interest remains abuse of discretion.

This Court made clear nearly 20 years ago the standards of review applicable when district courts review decisions regarding benefits under employee benefit plans:

---

[9] The "interim" denial letter referred to the letter Standard sent Petitioner after Standard asked the original claim specialist and medical expert to review their determinations when Standard received Petitioner's administrative appeal of that determination. That was the extra step Standard was not required to take, but did so voluntarily in order to avoid errors.

> Consistent with established principles of trust law, we hold that a denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.... Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion."

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989), *quoting Restatement (Second) Trusts* §187, *comment d* (1959). This Court recently reaffirmed that analysis in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, where the claimant sought benefits under a long-term disability plan. MetLife had granted Glenn's initial application, concluding that she met the plan's requirements for the initial 24 months of benefits. However, to qualify for benefits beyond 24 months, Glenn had to meet a stricter standard, which MetLife concluded she failed to meet. The district court ruled that MetLife had not abused its discretion in reaching that determination, but the Sixth Circuit reversed. In doing so, the Sixth Circuit took into account MetLife's structural conflict-of-interest – MetLife both evaluated claims and paid benefits on accepted claims – as a factor to be weighed in determining whether MetLife had abused its discretion. 128 S.Ct. at 2346-47.

MetLife challenged the Sixth Circuit's application of *Firestone*, arguing that the Court had erred in applying MetLife's conflict. *Id.* at 2349-50. After holding that the Sixth Circuit properly considered the conflict, this Court explained how such conflicts should "be taken into account on judicial review of a discretionary benefit determination." *Id.* at 2350. In doing so, this Court rejected the notion that including the conflict in the evaluation amounts to using some standard of review other than abuse of discretion:

> We do not believe that *Firestone*'s statement implies a change in the standard of review, say, from deferential to *de novo* review. Trust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee, while at the same time requiring the reviewing judge to take account of the conflict when determining whether the trustee, substantively or procedurally, has abused its discretion.

Glenn, 128 S.Ct. at 2350, *citing Restatement (Second) Trusts* §187, *comments d-j*; §107, *comment f.* The Court added that it is neither "necessary or desirable" for courts to establish special rules for burden-of-proof or other procedural or evidentiary rules that focus on the evaluator/payor conflict in ERISA benefit determinations. Because the conflict is "but one factor among many that a reviewing judge must take into account," and because benefit determinations arise in varied circumstances that each affect, in their own way, the degree of seriousness of the conflict, courts

must not attempt to develop a one-size-fits-all procedural system for conducting judicial review of benefit determinations. *Glenn*, 128 S.Ct. at 2351.

Instead, this Court made clear in *Glenn* that it meant what it said about the conflict in *Firestone* – the conflict is but one factor the judge takes into account and weighs together with other factors appropriate for the circumstances, in determining whether the plan administrator abused its discretion. The task is like those the judge undertakes in many other judicial decisions, assigning to each factor its inherent or case-specific importance under the circumstances. *Glenn*, 128 S.Ct. at 2351.[10] This Court affirmed the Sixth Circuit's decision to reverse MetLife's determination because the Sixth Circuit had applied the "combination-of-factors" method of review. The lower court gave the conflict weight to some degree, indicating that it would not have found the conflict, by itself, to be determinative. *Id.* at 2351-52.

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[10] Indeed, the Court made clear that its discussion of the *Firestone* elements (*see* 128 S.Ct. at 2347-48) did ***not*** constitute a detailed set of instructions and, instead, the Court warned that attempting to create formulas would "'falsif[y] the actual process of judging' or serve as 'instrument[s] of futile casuistry.'" *Id.* at 2352.

That statement answers Petitioner's erroneous charge that this Court should accept review and "amplify and implement its holding and the Department of Labor's intent that our judicial system must follow a uniform procedure and method in reviewing ERISA benefits claim decisions." (Pet. 16) Instead, each case must be handled based on its own circumstances.

In this case, although neither the Magistrate nor the District Judge had the benefit of this Court's decision in *Glenn*, the Magistrate engaged in an analysis similar to that used by the Sixth Circuit in *Glenn*. As noted, Standard's Plan delegates discretion and, therefore, Standard acted under a structural conflict-of-interest.[11] App. 20a-21a. The Magistrate noted the standards established in *Firestone*, that Standard had a structural conflict-of-interest, and that it was appropriate to review Standard's benefits determination for abuse of discretion. App. 20a-21a, 32a-33a.

Petitioner asks this Court to provide guidance on the meaning, *inter alia*, of the "higher than market-place" obligations imposed by ERISA statutes and regulations on a Plan Administrator's performance of its duty to conduct a "full and fair review" of adverse

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[11] Standard's Plan provides:

> Except for those functions which the Group Policy specifically reserves to the Policy owner or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

App. 20a-21a. The Ninth Circuit previously had held that the same language constitutes a delegation of discretion. *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 943 (9th Cir. 1999). Here, as in *Abatie*, the District Court's review properly was "informed by the nature, extent, and effect on the decision-making process of any conflict of interest that may appear in the record." 458 F.3d at 967.

benefits decisions, as well as the duty to provide notice of the right to appeal. (Pet. 14) In making that argument, Petitioner quotes language from *Glenn* discussing the "higher-than-marketplace quality standards" imposed on insurers under ERISA. This Court used that language to explain that ERISA imposes higher standards on Plan Administrators than are imposed on insurers generally, and supplements the marketplace and regulatory controls on insurers with judicial review of individual claim denials. 128 S.Ct. at 2350. Nothing in that analysis changes the fact that the District Court's standard-of-review remains abuse-of-discretion.

2. No split exists among the Circuits regarding the 2000 ERISA regulations that merits this Court's attention.

Petitioner contends that this case involves two splits among the Circuits that have not been addressed by this Court and that merit this Court's attention: (a) the meaning and implementation of ERISA regulations that create standard minimum procedures for "full and fair review" to guide claims processing, and (b) the remedies available for violations of those minimum requirements. (Pet. 8) In raising those challenges, Petitioner overstates the nature of the alleged problem in this case, and overstates what she claims is a conflict of interest based on pre-*Glenn* cases that are no longer good law.

a. No post-amendment Circuit split exists regarding the need to disclose information developed during the administrative appeal process.

Petitioner contends there is a split among the Circuits regarding the obligations of ERISA Plans or Insurers to disclose information prior to the filing of a lawsuit. She argues that the Eighth and Ninth Circuits require Plans and Insurers to disclose information developed during the administrative appeal process, while the Tenth and Eleventh Circuits hold that the only information the Plan or Insurer must disclose is information developed before the initial denial. (Pet. 15, 17-21) Petitioner misreads some of the cases, and fails to recognize that the cases requiring disclosure all deal with pre-amendment claims.

Petitioner quotes at length from *Abram v. Cargill, Inc.*, 395 F.3d 882 (8th Cir. 2005), acknowledging that *Abram* construes the regulations as they existed ***before*** the 2000 amendments. (Pet. 17-18) Those were significant changes to the regulations, and the Eighth Circuit no longer requires the Plan or Insurer to disclose information learned during the administrative appeal process. *See Midgett v. Wash. Group Intern. Long Term Disability Plan*, 561 F.3d 887, 896 (8th Cir. 2009), which notes that the Department of Labor's 2000 amendments distinguish between the documents and records "relevant to the claimant's claim for benefits" [29 C.F.R. §2560.503-1(i)(5)] and the records to be made available to a

claimant in the case of "an adverse benefit determination on review" [29 C.F.R. §2560.503-1(j)(3)-(5)]. The Eighth Circuit explained that by including the language "on review" in subsection 2560.503-1(j)(5), the Department differentiated the initial "adverse benefit determination" from later internal appeals of that decision. *Midgett*, 561 F.3d at 895.

Petitioner cited *Midgett* only in a footnote, noting that after the 2000 amendments, the "full and fair review" in the Eighth Circuit does not include reviewing and rebutting, prior to a determination on an administrative appeal, determinations made at the same level of appeal. 561 F.3d at 896. Petitioner acknowledges that *Midgett* brings the Eighth Circuit in line with the Tenth and Eleventh Circuits, both of which require disclosure only of information gathered or learned during the initial administrative proceeding. *Metzger v. UNUM Life Ins. Co. of America*, 476 F.3d 1161, 1166 (10th Cir. 2007);[12] *Glazer v.*

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[12] The Tenth Circuit explained:

> Permitting a claimant to receive and rebut medical opinion reports generated in the course of an administrative appeal – even when those reports contain no new factual information and deny benefits on the same basis as the initial decision – would set up an unnecessary cycle of submission, review, re-submission, and re-review. This would undoubtedly prolong the appeal process, which, under the regulations, should normally be completed within 45 days. 29 C.F.R. §2560.503-1(i)(3)(i).

476 F.3d at 1166. The District Court had reached a similar conclusion, ruling that subsection (h)(2)(iii) requires Plan

(Continued on following page)

Reliance Standard Life Ins. Co., 524 F.3d 1241, 1245-46, (11th Cir.), *cert. denied*, 129 S.Ct. 646 (2008).[13]

Petitioner argues that there still is a conflict between the Ninth Circuit and the Eighth, Tenth, and Eleventh Circuits. She attempts to rely on what she contends is a rule in the Ninth Circuit requiring Plan Administrators to disclose all material developed pre-suit as part of the "meaningful dialogue" guaranteed by ERISA. Petitioner cites *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) and *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863 (9th Cir. 2008) as support for her argument. (Pet. 15, 19-21) Petitioner

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Administrators to release only documents relied on in the initial benefit determination – *i.e.*, before the claimant took an administrative appeal. However, documents generated during the administrative appeal process must be made available only ***after*** the Plan Administrator reaches its final decision on appeal. *Id.*

[13] The Eleventh Circuit explained that Subsection (h)(2)(iii) requires the Plan Administrator to produce all "relevant" documents, which are defined as documents that were "relied upon" or "submitted, considered, or generated in the course of making the benefit determination." 29 C.F.R. §2560.503-1(m)(8)(i)-(ii). Because the insurer had not relied on the reports the claimant sought or used in the course of making a benefit determination until that determination had, in fact, been made, there was no obligation to turn over that information to the claimant until after that determination was made. Thus, documents generated or used ***during*** the administrative appeal process did not have to be turned over until after the final decision on appeal was made. 524 F.3d at 1245.

reads more into those Ninth Circuit decisions than the Court stated.

As Petitioner acknowledges (Pet. 19), *Booton*, like *Abram*, addressed the pre-2000 amendment version of the ERISA regulations. Petitioner quotes language from *Booton* concerning the need to engage in "meaningful dialogue" with the claimant, arguing that such language requires disclosure of material developed pre-suit. (*Id.*) However, the "meaningful dialogue" identified by the Ninth Circuit was found in the pre-2000 amendments to the ERISA regulations, which identified four kinds of information the Plan Administrator must provide to a claimant, in language that could be understood by a claimant, whenever a claim was denied:

> (1) The specific reason or reasons for the denial; (2) Specific reference to pertinent plan provision on which the denial is based; (3) A specific description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

110 F.3d at 1463, *discussing* 29 C.F.R. 2560.503.1(f) (1997). *Booton* involved an insurer who failed to explain the reason for its decision or to request needed medical information; *Booton* did not involve an insurer who failed to provide claimant with

information the insurer developed during the administrative appeal process (*i.e.*, after the initial adverse determination but before the final decision is made on an administrative appeal). Thus, nothing in *Booton* addressed the issue for which Petitioner attempts to use it as authority.

The same is true for *Saffon* – which also involved the pre-2000 amendments to the ERISA regulations.[14] In *Saffon*, after discussing the appropriate standard of review, the Ninth Circuit repeated the "meaningful dialogue" language from *Booton*, and discussed the history of MetLife's analysis of a claim for long-term disability benefits. After paying short-term benefits and then granting the claimant long-term disability benefits, MetLife asked a physician to review claimant's medical records. Dr. Thomas found that claimant's file "lacks detailed objective, functional findings or testing which would completely preclude" an effort to return to work. 522 F.3d at 869. MetLife forwarded Dr. Thomas' report to claimant's neurologist, who sent MetLife a detailed letter discussing claimant's reported symptoms, the neurologist's unsuccessful efforts to alleviate them, and "[o]bjective evidence of cervical pathology." *Id.* The claimant also

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[14] Although *Saffon* was a 2008 decision, it involved events from December 2001, resulting in claimant stopping work and applying for disability benefits. 522 F.3d at 866. The 2000 amendments to the ERISA regulations applied to claims filed on or after the first day of the plan year beginning on or after July 1, 2002, but no later than January 1, 2003. 64 Fed. Reg. 70,246 (Nov. 21, 2000).

responded with a letter explaining her condition. MetLife sent the two letters back to Dr. Thomas for a second review. He again concluded that the file "lacks clear, sequential, detailed, objective clinical information which would completely preclude [claimant] from an attempt at return to work." *Id.* MetLife faxed that information to the neurologist, giving him 10 days to respond, but did not notify claimant. The neurologist did not respond within 10 days. MetLife then terminated claimant's benefits, notifying her she could appeal by providing

> medical evidence from doctor(s) treating you for a condition that indicates you are under the appropriate care and treatment and objective medical information to support your inability to perform the duties of your occupation.

Id. Claimant appealed, attaching her most recent MRI and another letter from the neurologist. MetLife submitted the appeal to Dr. Menotti, who read the file and concluded there were not enough "'objective medical findings and office notes that have continued to flow into this file, that convince this reviewer that the claimant's self reported headache and chronic pain syndrome has been enough to preclude her from' working." *Id.* at 869-70. MetLife denied the appeal, stating that medical information furnished with her claim indicated diagnoses of chronic headaches, chronic pain syndrome, etc., but that the determination of disability is not based on the presence of diagnoses but on functional ability supported by

clinical evidence that would substantiate symptoms consistent with those reported by the patient and medical providers. *Id.* at 870. MetLife added:

> ... It is not clear what [the neurologist] used as a basis for [his diagnosis of your] reported limitations as we've not been furnished with a Functional Capacity Evaluation that would objectively measure and document your current level of functional ability.
>
> ... The MRI of April 28, 2003 documents degenerative changes [in your cervical spine], but indicates this is unchanged from the prior January 12, 2002 MRI.

Id.

In reviewing the denial, the Ninth Circuit returned to its statement in *Booton* that the ERISA regulations called for a "meaningful dialogue" between claims administrator and beneficiary, adding that MetLife was required to give claimant a "description of any additional material or information" that was "necessary" for her to "perfect the claim," and to do so "in a manner calculated to be understood by the claimant." *Id.*, *quoting* 29 C.F.R. §2560.503-1(g). It was that requirement that MetLife failed to meet. *Id.* at 870-71. The Court did not fault MetLife

for failing to provide claimant with information developed during the pre-suit process.[15]

Again, neither *Booton* nor *Saffon* – both of which address the pre-2000 amendment regulations – establish the conflict that Petitioner attempts to establish with case law from the Eighth, Tenth, and Eleventh Circuits. Thus, Petitioner's argument (Pet. 22) that *Saffon* demonstrates the split because Standard committed the same kinds of violations as in *Saffon* based on "including new explanations for its denial of benefits in the 'interim' denial letter of September 24, 2003, without giving [Petitioner] an opportunity to then submit additional evidence relevant to those explanations" is wrong. Although a panel of the Ninth Circuit may have concluded that Standard violated the rules established in *Saffon*, that Court did ***not*** determine that there was a conflict. Indeed, Petitioner ***did not even raise the issue of a conflict among the Circuits***. That is likely due to the fact that, if one ignores the fact that the Ninth Circuit

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[15] The Ninth Circuit does address information in MetLife's termination letter regarding the absence of a Functional Capacity Evaluation that would objectively measure and document claimant's current level of functional ability. 522 F.3d at 871. That analysis addresses the prohibition against adding new grounds for denial to the final appeal determination, when it would be too late for the claimant to address. *Id.* at 871-72. Petitioner refers the Ninth Circuit's requirement that a District Court allow a claimant to present additional evidence on any newly raised issues. (Pet. 20) That is part of the second alleged conflict raised by Petitioner (*see* Pet. 25-26) and, therefore, is discussed below.

was dealing with the pre-2000 amendments to ERISA regulations while the Eighth, Tenth, and Eleventh Circuits are addressing the effect of those amendments, Petitioner benefits from the fact that the Ninth Circuit imposes more stringent requirements on Plan Administrators.

Petitioner attempts to use *Saffon* for other purposes as well, contending that other parts of *Saffon* somehow establish a conflict between the Ninth Circuit and other Circuits. In that regard, Petitioner cites the discussion in *Saffon* regarding the degree of deference to which a Plan Administrator's decision is entitled on judicial review based on the Administrator's course of dealing with the claimant, arguing that the Administrator's violations of its duty in *Saffon* were by means of "precisely the same tactics Standard used here." (Pet. 21) Petitioner attempts to compare the "opaque communications" in *Saffon* with Standard's communications with Petitioner. (*Id.*) Petitioner ignores the significant differences between the two cases. First, the requested information involves information that ***does not exist***. Contrary to Petitioner's efforts to re-characterize the facts, the relevant information involves any neuropsychological exams establishing Petitioner's status during the 180-day benefit-waiting-period. No such record exists because no such exam was done.

Petitioner also contends that Standard violated the regulations by failing to identify, in the initial denial letter, what she needed to submit to perfect her claim. She argues that Standard should have told

her that she needed to submit the results of a neuropsychological exam revealing neurocognitive impairment. That argument is based on a misreading of the regulations and elevates the importance of neurocognitive testing out of all proportion.

Contrary to Petitioner's argument, Standard's decision was ***not*** based solely on the lack of evidence of neurocognitive impairment and, therefore, Petitioner could ***not*** have remedied the problem by submitting such evidence alone. Instead, Standard denied her claim because the medical records did not reveal ***any*** impairment – physical, mental, or neurocognitive – as of November 2002.

Moreover, requiring a Plan Administrator to advise a claimant of missing information she may need to ***perfect her claim*** is not equivalent to requiring the Administrator to tell the claimant exactly what she needs to submit for her claim ***to be approved***. As the Fourth Circuit explained:

> Subsection (f)(3)[16] is only implicated when there remain unresolved, material factual questions about which a plan administrator or fiduciary must have information in order to review the denial of the claim.... [Claimant] has somehow conflated these purposes and come to the erroneous belief that MetLife is under an obligation to inform her

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[16] That provision was renumbered as (g)(1)(iii) with the 2002 revisions to the regulations.

> of what she needs to tell MetLife in order to obtain disability benefits. That is not MetLife's role as a fiduciary. MetLife must treat each claimant with procedural fairness, but, because it must also guard against improper claims, it is not its duty to affirmatively aid claimants in proving their claims.

Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 236 (4th Cir. 1997).

Standard complied with the applicable regulations. In a detailed 8-page letter, Disability Claims Specialist Steven Poindexter quoted the relevant policy provisions, summarized the medical records Standard had, and set out the opinion of Standard's physician consultant. Poindexter then concluded:

> After a complete review of your claim file, including your statements and the results from the medical file review, we find that as of November 2002 your depression had markedly improved, given your appropriate treatment from antidepressant medications as noted by Dr. Borror. Although Dr. Teitelbaum diagnosed you with Chronic Fatigue Syndrome and Myofascial Pain Syndrome in December 2002, review of the available medical records does not support this diagnosis. Furthermore, the length of time between your visits with Dr. Teitelbaum is not consistent with severe ongoing limitations and restrictions. Lastly, your fall in February of 2003 appears to be related to the combination of your medications and supplements, rather than a specific medical

> condition. As a result, we find that the information in your claim file does not provide satisfactory written proof that as a result of physical disease, injury, pregnancy or mental disorder you are unable to perform with reasonable continuity the material duties of your Own Occupation throughout the 180-day benefit waiting period ending December 26, 2002 and continuing. Therefore, your claim for LTD benefits is denied.

App. 54a-55a. Poindexter added:

> If you request a review, you will have the right to submit additional information in connection with your claim. ***Additional information, which would be helpful to a reconsideration of your claim, includes medical records or chart notes indicating that your medical condition is more severe than we previously understood*** and continues to support your inability to perform the material duties of your own occupation ***throughout the 180 day benefit waiting period*** ending December 26, 2002 and continuing.

App. 48a, emphasis added.

Although Petitioner argues that the statement was vague and did not notify her that a neuropsychological examination was needed, Poindexter described in plain terms exactly what was needed: ***any*** evidence that Petitioner's condition was more severe than indicated in Dr. Borror's records. The fact that Petitioner understood the need to submit evidence of

functional restrictions is clear from her subsequent submission of additional medical records from Drs. Teitelbaum, Rastogi, and Patel, together with journal articles describing fibromyalgia and CFS, and the notice that Social Security Administration ("SSA") had approved her disability claim. If the additional information had documented the severity of Petitioner's condition during the benefit-waiting-period, it could have supported her claim (although not necessarily assuring approval), even without neuropsychological testing.

As it was, none of the information Petitioner submitted in connection with her appeal provided contemporaneous evaluations of her condition during the relevant period. Instead, Dr. Teitelbaum relied on ***subsequent*** statements about Petitioner's condition during that period, and Drs. Rastogi and Patel simply accepted Dr. Teitelbaum's diagnoses without question.

The issue is not that Standard was seeking evidence of neurocognitive deficiencies but failed to advise Petitioner that she needed to submit such evidence; instead, the issue is that Standard was seeking ***any*** evidence that Petitioner's condition was more severe during the benefit-waiting-period than was indicated in Dr. Borror's medical records made contemporaneous to the relevant period. Despite Petitioner's attempt to narrow the issue to the lack of neurocognitive testing, Poindexter's letter adequately explained what evidence Petitioner needed submit in support of her claim and, therefore, the letter met the requirements of 29 C.F.R. §2560.503-1(g)(1)(iii).

Whether the evidence was of neurocognitive testing or something else is a non-issue, and the neurocognitive report Petitioner did submit was irrelevant because it did not (and could not) accurately assess Petitioner's functionality during the relevant period.

Petitioner states that the Ninth Circuit disagreed with that analysis and called Standard's conduct a violation of conduct outlawed in *Saffon* and *Abatie*. (Pet. 23) What the Ninth Circuit criticized was the inclusion of new explanations in the interim denial letter, thus not allowing Petitioner an opportunity to present additional evidence relevant to those matters. App. 2a. The question of raising new explanations after the initial denial is different than not communicating information learned by the Plan Administrator (although there can be overlap). More importantly, once again, (1) Petitioner has not established a Circuit split based on the post-2000 ERISA regulation amendments, and (2) to the extent this Court ignores the pre- and post-amendment differences, Petitioner is the beneficiary of stricter requirements. She has hardly established a need for this Court to address a need for greater protections.

Next, Petitioner attempts to compare Standard's reliance on Dr. Borror's statement in her chart notes about Petitioner's improvement to the discussion in *Saffon* about taking a doctor's statements "out of context or otherwise distorting it in an apparent effort to support denial" and to an authority cited by this Court in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, in which a reviewing physician reports the

limits imposed on his work, including that he was instructed to use language to support denial, that he was not permitted to request additional information, and he was not allowed to help the claimant perfect her claim. [*Id.*, *citing Saffon*, 522 F.3d at 873; John H. Langbein, *Trust Law as Regulatory Law*, 101 NW. U. L. Rev. 1315, 1319 (2007).] This case is nothing like *Saffon* or the article she cites.

First, Petitioner's analysis relies on information not in the record before the Plan Administrator. The Record at that time indicated that Petitioner's condition had improved markedly and that before the end of the elimination period she was feeling better than she had in years. It was that information from Dr. Borror's chart notes that Standard's medical expert used in the analysis. Further, unlike in *Saffon*, there was no misuse of the statement – no tag end of the statement was left off, thereby distorting the meaning of the statement. Finally, unlike in *Saffon* or the article on which Petitioner attempts to rely, Standard's medical experts explained why they did not accept Dr. Teitelbaum's diagnosis, including the use of more than 20 vitamins and supplements, the fact that he had met with Petitioner so few times and did not plan to meet with her for a lengthy period of time, and that his diagnosis was not consistent with the medical tests or the other diagnoses of Petitioner's conditions. App. 46a-47a; 57a-59a.

b. Petitioner has not established a relevant Circuit split regarding whether a reviewing court should admit evidence beyond the administrative record.

Petitioner contends that there is a split among the Circuits regarding whether and to what extent a reviewing court should admit additional evidence beyond the administrative record. Petitioner cites three Ninth Circuit cases in support of that argument – *Saffon, Booton,* and *Abatie* (Pet. 15) – but later indicates that cases cited within those Ninth Circuit cases demonstrate a Circuit split because the cited cases do not permit the admission or consideration of additional evidence. (Pet. 25-26) However, the issue is not relevant for this case.

First, as discussed above, the evidence that Petitioner claims she was precluded from presenting is evidence about Petitioner's neurocognitive condition ***after*** the relevant time period. Again, following Standard's final decision on administrative review, Petitioner filed suit and sought to admit evidence outside the administrative record that she claims would have shown her neuropsychological deficit. What Petitioner continues to ignore was that what the reviewing doctor had said should have been included in the file were records of psychiatric or neurocognitive tests, if any had been done. App. 15a-16a. But none had been done. What Petitioner sought to have considered was evidence of her neurocognitive condition at a time that would not establish that she

had remained disabled throughout the benefit-waiting-period. Because the evidence she sought to have considered did not cure the defect, the questions whether such evidence should be considered, or whether there is a valid Circuit split, are not questions that this Court needs to consider.

In any event, even if Petitioner can establish that there is an existing Circuit split and that the evidence she sought to submit could somehow demonstrate her neurocognitive condition during the relevant time period, the Ninth Circuit determined both (1) that the District Court should have admitted the evidence, and (2) that the Ninth Circuit would, itself, consider the additional evidence. App. 3a. Even with that additional evidence, the Ninth Circuit still did not find a basis for rejecting Standard's determination denying Petitioner's claim for long-term disability benefits.

Petitioner erroneously contends that the Ninth Circuit failed to meaningfully consider the additional evidence. (Pet. 33) Petitioner is wrong. Again, Standard had already explained what was wrong with Petitioner's other evidence – unlike in the cases on which Petitioner relies, Standard had explained what was missing from that evidence, the conflicts in Dr. Teitelbaum's diagnosis with the objective medical tests and his treatment plan, and the absence of supporting documentation to address Petitioner's condition during the elimination period. Neither the District Court nor the Ninth Circuit had problems with Standard's explanations regarding those

matters. The fact that Petitioner disagrees with those explanations does not make them suspect.

The only area with which the Ninth Circuit had concerns was the failure to notify Petitioner of the need for reports of neurocognitive during the relevant time-period, if they existed, which led the Ninth Circuit itself to consider Petitioner's additional evidence. The Ninth Circuit then held that "Petitioner submitted no contemporaneous medical evidence of her inability to work for the entirety of the relevant six-month disability waiting period. In fact, she reported to her physician that she felt '100% better ... better than she has felt in years,' in the fifth month of the relevant period." App. 3a-4a. The Ninth Circuit adequately considered the evidence, and simply disagreed with Petitioner's analysis. That does not justify this Court granting *certiorari*.

B. Petitioner failed to establish a need for this Court to exercise its supervisory power to decide whether "full and fair review" requires more than what Petitioner received here.

Petitioner contends that while this Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, *supra*, requires a weighing of a combination of factors, this Court failed to indicate how that is to be done in a way that implements "full and fair review through judicial enforcement of the regulations." (Pet. 27) Petitioner further contends that this case conflicts

with *Glenn* because a heightened scrutiny applies to a Plan Administrator performing under a conflict of interest requiring a balancing of factors to determine the impact of that conflict on the determination regarding benefits, but that (a) the Ninth Circuit failed to articulate what combination of factors it weighed, (b) the Court actually relied on only one factor – the procedural violation – and (c) the Court concluded, without explanation, that whatever violations Standard committed, they "did not rise to the 'wholesale and flagrant' level required for *de novo* review." (Pet. 27-28) As discussed above, Petitioner fails to accurately account for the history of this case.

Moreover, this Court made clear in *Glenn* that where a Plan Administrator has discretion to interpret the policy, the standard of review remains abuse of discretion. The conflict of interest is a factor to be considered in determining whether the Plan Administrator abused its discretion, and does ***not*** convert the standard to *de novo* review. 128 S.Ct. at 2347-48, 2350-51 (noting that how the conflict is to be taken into account on judicial review is that it is to be considered as a factor, which varies with the circumstances, and that if Congress had wanted to impose *de novo* review, it would have said so). This Court also clearly stated that it would ***not*** establish procedures, create burden-of-proof rules, or other procedural or evidentiary rules focused narrowly on how to handle the conflict-of-interest issues. Instead, this Court explained that district courts are well equipped to deal with such issues, just as they deal

with many other such issues in addressing claims involved in areas of trusts, credibility determinations, etc. *Id.* at 2351. Again, nothing about this case demonstrates a need to change that analysis or this Court's perspective.

CONCLUSION

For the reasons stated above, this Court should deny the Petition for Writ of Certiorari.

Respectfully submitted,

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